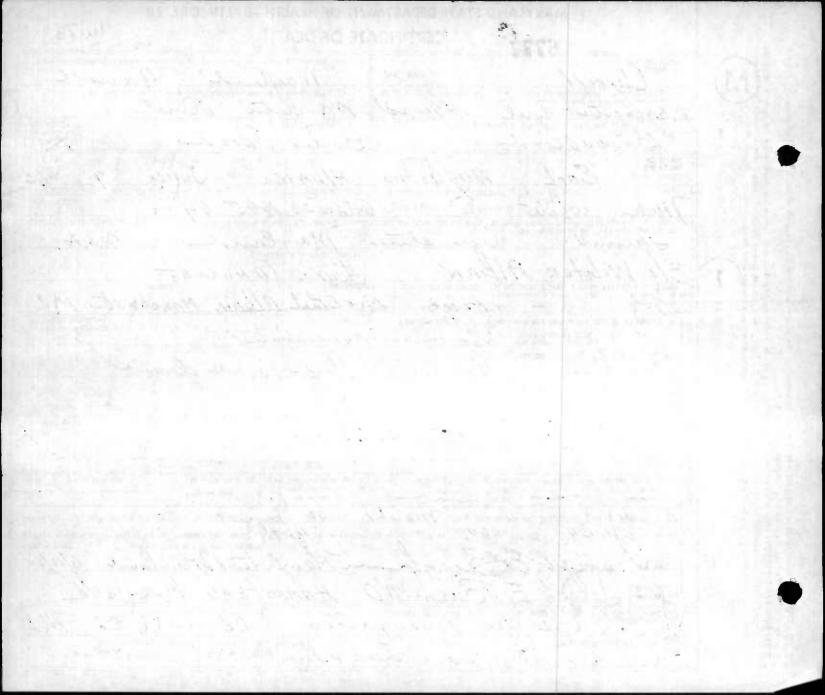
death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18



					001-1	
1. PLACE OF DEATH a. COUNTY	Carroll	MARYLAND	2. USUAL RESIDENCE (W. o. STATE Maryla	here deceased lived. If institution b. COUNTY F	Residence befare admission)	
b. CITY OR TOWN (I RURAL and give no Sykesv		c. LENGTH OF STAY IN 16		autside carporate limits, write RUR	AL and give nearest tawn)	
OR INSTITUTION	TAL (If not in haspital, give street Springfield Sta		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES NO	
3. NAME OF DECEASED (Type ar print)	First Andrew	Middle	Annan	4. DATE Manth OF June	Day Year 60	
s. sex	6. COLOR OR RACE 7. MARK		B. DATE OF BIRTH  June 15, 1876	last birthday)	FUNDER 1 YEAR IF UNDER 24 HRS. Manths Days Haurs Min.	
clerk in d	ON (Give kind af wark dane 10b. king life, even if retired)  arug store	KIND OF BUSINESS OR INDU	Maryle	and	U.S.A.	
13. FATHER'S NAME	obert L. Annan		14. MOTHER'S MAIDEN	Alice Colombi	ia Motter	
1S. WAS DECEASED EVE (Yes, no, or unknown)	R IN U. S. ARMED FORCES? 16. (If yes, give war or dates of service)		ingfield Hos	Addres		
18. CAUSE OF DEA	ATH [Enter anly one cause per li	-			INTERVAL BETWEEN ONSET AND DEATH YEARS	
	ns, if any, which e ta immediate (b) Generalized arteriosclerosis years					
lying cause last.	(c)	Severe nephroso			years	
CBS. ass	soc. with cereb	ral arterioscle	erosis, with	psychotic reacti	ion 19. Was autopsy Performed? Yes NO	
OR CONTRIBUTING	AS UNDERLYING   20b. DES G   CAUSE OF DEATH MEDICAL EXAMINER)	CRIBE HOW INJURY OCCURRE	D. (Enter nature af injury in	Part I ar Part II af item 18.)		
Y 20c. TIME OF INJUR Haur a. m. p. m.	While		ACE OF INJURY (Hame, fari ctary, street, affice bldg., et		(Caunty) (State)	
21. I certify the	at <b>(X</b> (this hospital) attendised alive on June 23	ded the deceased from)	March 16, 19 death occurred at 3:	05, Roll the causes and	on the date stated above.	
220. SIGNATURE	is f. Tha		M.D. ATTENDING A	AED. STAFF PHYS.	June 24, ST 90	
22c. PHYSICIAN'S NAME (Type)	Ellis S. Margol	in, M.D.	Springfiel	d Hospital, Syk	esville, Md.	
23a. BURIAL, CREMATIC REMOVAL (Specify) Burial	0N, 23b. DATE THEREOF 6/27/60	23c. NAME OF CEMETERY C			Frederick Co.	
24. FUNERAL DIRECTOR	S'S SIGNATURE	ADDRESS Committee	7		RAR'S SIGNATURE	

VR A1S (4) 1SM 9/59

Wilson

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ing statement, years			_estroke_	
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TO FUNERAL TO HOSPITA

VS A15 (4) 15M 9/SS

### MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6779

### CERTIFICATE OF DEATH

06745 Reg. Dist. No.

-	
1.	PLACE OF DEATH  a. COUNTY  MARYLAND  2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  b. COUNTY  b. COUNTY
1	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town)
K	d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION OR INSTITUTION ON A FARM? YES NO
3.	NAME OF DECEASED (Type or print) MAYBELLE L' ARNOLD 4. DATE OF DEATH JAME 29 1960
L	SEX   6. COLOR OR RACE   7. MARRIED   NEVER MARRIED   B. DATE OF BIRTH   9. AGE (In years less birthday)   Months   Days   Hours   Min.   WIDOWED   DIVORCED   Floring   Widows   Widow
100	Justing most of working life, even if retired)  (AM) Compared to the compared
L	PATHER'S NAME  14. MOTHER'S MAIDEN NAME  MANY SMILLY WORLD
15. (Ye	WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT  (If yes, we war or dates of service)  (If yes, we war or dates of service)
-	18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c))  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  IMMEDIATE CAUSE (a)
	Canditions, if any, which gave rise to immediate coess (a), stoting the under-
ATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED?  YES   NO   PART
CERTIFICATION	20a. ACCIDENT WAS UNDERLYING   20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)  OR CONTRIBUTING   CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
MEDICAL	20c. TIME OF INJURY Month, Day, Year Hour a. m., 19 While Not while at work at
	21. I certify that I attended the deceased from. 1934, to 1950, that I last saw the deceased alive an 1950, and that death accurred at 500 M, from the causes and an the date stated above.  ADDRESS (Street, city endown, state)  DATE SIGNED
	PHYSICIAN'S W. JENNETTE MY Wastminster My NAME (TYPO)
22	D. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) (Stole)
23.	FUNERAL DIRECTOR'S SIGNATURE  ADDRESS  24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE  DATE IN 5 '60 Called & Known

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ngh is sign that yet		Acres de la company	Secure (e.v. etter f.t.)
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	of territoring Medic		A STATE OF THE STA

# HEALTH DEPT.

PLACE OF DEATH

or its designated agent, priar to burial, cremation, or removal, and in any event

VS. A15ME 5M 2/57

# MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

)	CERTIFIC	ATE	OF [	DEA	TH	Reg. Disk	NG. 7	46	
Ī	2. USUAL RESIDEN	CE (Where	deceased	lived.	If institution	on: Residence	before	odmission)	
H	o. STATE Me	wirl a	nd	b.	COUNTY	Daina	Ca		•

TY OR TOWN (If outside corp Suitland  REET ADDRESS 4615 Porte Lost ach Lost BIRTH 1-1929 RTHPLACE (Stoke or foreign corr rginii HER'S MAIDEN NAME Katherine R  Tal record  epileptic sei	Month 6- 9. AGE (In years 31 birthday) yrs. buntry)  osetta Address Sykesv:	Doy 5  IF UNDER 1YEAR Months Days  12. CITIZEN O U.S.A.	e. IS RESIDE ON A FA YES NO YES NO 19 60 IF UNDER 24 Hours Min	NCE RM? D 3.	
Losi de Death  BIRTH 1-1929  RTHPLACE (Stole or foreign constitution of the constituti	Month 6-  9. AGE (in years 3 last birthday) yrs.  ountry)  osetta  Address  Sykesv:	IF UNDER 1YEAR Months Days  12. CITIZEN O U.S.A.	Yes No. 1960  IF UNDER 24 Hours Min F WHAT COU	HRS.	
BIRTH 1-1929 RTHPLACE (Stole or foreign or rginia) HER'S MAIDEN NAME Katherine R IT	9. AGE (in year) 31 birthday) yrs. aunity)  osetta Address Sykesvi	IF UNDER 1YEAR Months Days  12. CITIZEN O U.S.A.	1960 IF UNDER 24 Hours Min F WHAT COU	HRS.	
1-1929  RTHPLACE (Stole or foreign or rginia) HER'S MAIDEN NAME  Katherine R  R  R  R  R  R  R  R	31' yrı.   ouniry) osetta Address Sykesvi	Months Days  12. CITIZEN O  U.S.A.	Hours Min F WHAT COU  Yland.  EVAL BETWEEN		
rgin <b>ii</b> HER'S MAIDEN NAME  Katherine R  II  al record	osetta Addrem Sykesvi	U.S.A.	yland.	NTRY?	
Katherine R	Addren Sykesvi	INTE	RVAL BETWEEN		
al record	Sykesvi	INTE	RVAL BETWEEN		
epileptic sei		INTE	RYAL BETWEEN ET AND DEATH		
ED TO THE TERMINAL DISEASE	E CONDITION GIVE	N IN PART 1(0)	PERFORME	7	
PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 199. W.  PER YES 2  200. EXTERNAL CAUSE WAS PRIMARY   or CONTRIBUTING   20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Port II of item 18.)  CAUSE OF DEATH.  20c. TIME OF INJURY Month, Doy, Yeor Hour of many in Part I or Port II of item 18.)  Not while Not while of work of wo					
uicide, Hamicide HIEF MEDICAL EXAMINER SSISTANT MEDICAL EXAMINER	Undeter		DATE SIGNE	D	
y Suitle	and Rd.Pr	GO.CO.	(Stote) Md.		
1 3 5	t qualifying property of injury in Part I ar Port II  URY (Home, form, 20f. (City office bldg., etc.)  d an Autapsy , Ir dicide , Hamicide , Hamicide , Hamicide , Hamicide , SISTANT MEDICAL EXAMINER , PUTY MEDICAL EXAMINER , STATE , Suitly , 240. REC'D BY REGIST	t qualifying phrase  of injury in Part I ar Port II of Item 18.)  URY (Home, form, 20f. (City or town) office bldg., etc.)  d an Autapsy, Inspection, vicide, Hamicide, Undeter  HIEF MEDICAL EXAMINER  PUTY MEDICAL EXAMINER  PUTY MEDICAL EXAMINER  22d. LOCATION (City, town, or y Suitland Rd.Pr  24o. REC'D BY REGISTRAR 24b. REGIST	t qualifying phrase  of injury in Part I ar Port II of item 18.)  URY (Home, form, 20f. (City or town) (County)  office bldg., etc.)  d an Autapsy , Inspection , Inquiry , incide , Hamicide , Undetermined manner  HIEF MEDICAL EXAMINER , SISTANT MEDICAL EXAMINER , PUTY MEDICAL EXAMINER , PUTY MEDICAL EXAMINER , SISTANT MEDICAL EXAMINER , SISTANT MEDICAL EXAMINER , SISTANT MEDICAL EXAMINER , PUTY MEDICAL EXAMINER , SISTANT MEDICAL EXAMINER MEDICAL EXAMINER , SISTANT MEDICAL EXAMINER M	URY (Home, form, 20f. (City or town) (County) (State of injury in Part I ar Port II of Item 18.)  URY (Home, form, 20f. (City or town) (County) (State of Injury) (State of In	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

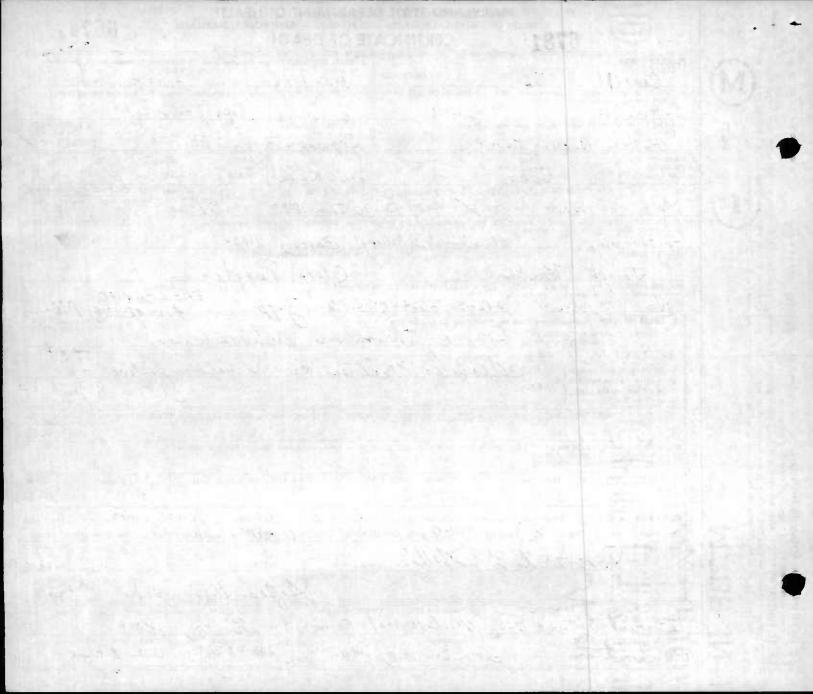
06747

	U U T	4 0 0 Pilm	0266 6/75/	Soint		*
1. PLACE OF DEATH o. COUNTY		MARYLAND	2. USUAL RESIDENCE (WI o. STATE		If institution: Resident	nde
b. CITY OR TOWN (if or RURA) and give near	utside corporate limits, write st town)	c. LENGTH OF STAY IN 16	c. CITY OR TOWN (IF	outside corporate lim	its, write RURAL and g	pive nearest lown)
d. NAME OF HOSPITAL OR INSTITUTION	(If not in haspital, give street		Skyway 4 1	Barriew To	de-claire	e. IS RESIDENCE ON A FARM? YES NO
NAME OF DECEASED (Type or print)	First	Middle	BOOKER	4. DATE OF DEATH	Month June	8 Pay Year 19 6
Male 6	widows	IED NEVER MARRIED DIVORCED	B. DATE OF BIRTH		(In years birthday) (80 yrs.   IF UNDER   Months	1 YEAR IF UNDER 24 HR Days Hours Min.
factory ma-		KIND OF BUSINESS OR INC		14d.	12. CITI	ZEN OF WHAT COUNTR
3. FATHER'S NAME	1 Booken		14. MOTHER'S MAIDEN	Papaler		
S. WAS DECEASED EVER IN (Yes, no, or unknown) (If y	N. U. S. ARMED FORCES? 16.	SOCIAL SECURITY NO. 17.	INFORMANT  Mrs-Marie 3.	eb A	Pt-t-Box	95 mls
Canditions, if ony, gave rise to imm couse (a), stoting the lying cause lost.	ediate DUE TO	califer Mm	leter ow	rl, Cars	line forter	8 June 6
CATIC			UT NOT RELATED TO THE TERM  RED. (Enter nature of injury in			19. WAS AUTOPS PERFORMED? YES NO
	CAUSE OF DEATH				SAME IN	
20c. TIME OF INJURY Hour o. m. p. m.	Month, Doy, Year 20d. If While of war	Not while	PLACE OF INJURY (Home, farr factory, street, office bldg., et		(c)	County) (Stat
21. I certify that (	l) (this haspital) attend	1 10	death accurred at 2.	60, ta 8		that (I) (we) la
22a. SIGNATURE	mard &	· Still'	ATTENDING M	IED. STA		22b. DATE SIGNE
22c. PHYSICIAN'S NAME (Type)			22d. ADDRESS	Reside	mel	The state of the s
23a. BURIAL, CREMATION, REMOVAL (Specify	23b. DATE THEREOF	New Cathedr	or CREMATORY  Cem	R. 1L	City, town, or county)	(Stote) .
24. FUNERAL DIRECTOR'S	IGNATURE 6	Lex Burnie	14 d. 250. REC	JUN 13 '60	25b. REGISTRAR'S SIG	S. Kraus

after death. Page 4 TO HOSPI BRATENDING PHYSICIAN: The law requires that the death certificate be executed within 24 h after death. Page 1 may be recorded by the haspital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shauld be detached for use as the burial-transit permit. Then please remave carbon pages. Pages 1 and 2 should be filled with the State Board of Health prior to burial, crematian, or remayal, and in any event, within 72 have after death.

VR A1S (4) 1SM 9/S9



CATE OF DEATH

06748

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PLACE OF DEATH	arall.	MARYL

nerge

)		PLACE OF DEATH O. COUNTY ORKALL MARYLAND 2.	USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  b. COUNTY  ALLO  A
	7	b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 1b AURAL - AMARICAL S YELLOW)	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
		d. NAME OF HOSPITAL (If for in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS Acadely Park  6. IS RESIDENCE ON A FARM? YES NO
	[	NAME OF DECEASED (Type or print) EFFYE M. BRAND	DENBURG DEATH JUNE 22 1960
1		A. WIDOWED DIVORCED A	ATE OF BIRTH  9. MSE (In years of birthdoy)  81 yrs.  1 FUNDER 1 YEAR IF UNDER 24 HRS.  Months Days Hours Min.
	2	On USUAL OCCUPATION (Give kind of work done during most of working life even if retired)	ma U.S.A.
	1	Joseph R. Musser	amanda E. Lane
	13.	WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFOR	Wallace Haumenig - ofykisville met.
		1B. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)  ONTO Y  Three  Th	a bosis, arternos levolte ONSET AND DEATH
		Conditions, if ony, which gove rise to immediate (b) hearth durant,	Carles forlure to
	7	lying couse lost. DUE TO (c) ansarkin . (d)	vonie breken Syntrum 22 Jane 60
1	CATION		T RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED?  YES NO
	L CERTIFI	OR CONTRIBUTING   CAUSE OF DEATH	nter noture of injury in Port I or Port II of item 18.)
	MEDICAL	20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 40 Foctory 4 While 5 work 4 of work 5 work 5 work 5 work 5 work 6 work 7 work	OF INJURY (Home, form, 20f. (City or town) (County) (Stote)
		21. 1 certify that (1) (this haspital) attended the deceased fram	h accurred at L.M., from the causes and an the date stated abave.
		220. SIGNATURE Howard & Hall 3 M.D.	ATTENDING MED. STAFF PHYS.   22b. DATE STAFF PHYS.   3 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2
		22c. PHYSICIAN'S HOWARD E, HALD	SYKESVILLE, MD
	23a	30. BURIAL, CREMATION, 23b. DATE THEREOF, 23c. NAME OF CEMETERY OR CR. REMOVAL (Specify) 4-25-60 Mt Ville	SMATORY 23d JOSATION (City, town, or county) (Stote)
1	24.	Sultation A Haight - Hugesville	250. REC'D OF REGISTRAR 25b. REGISTRAR'S SIGNATURE CITCHER S. Huma

TO HOSPIT.

R ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 has after death. Page 4 may be received by the haspital or otherding physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shauld be detached for use as the burial-transit permit. Then please remave carbon papers. Pages 1 and 2 shauld be filed with the State Board at Health priar to burial, cremation, ar removal, and in any event, within 72 hours offer death.

VR A1S (4) 1SM 9/59

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	100			ar death		
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		A SECOND				

# MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND 6782 CEDITEICATE OF DEATH

06749

1. PLACE OF DEATH								
U. COUNTY OALL	oll	MARYLAN	2. USUAL RESIDENCE o. STATE MATY	(Where deceased I	ved. If institution b. COUNTY	Residence l	Tewn	sion)
b. CITY OR TOWN (If	outside corporate limits, writ	c. LENGTH OF STAY IN 1	b g. CITY OR TOWN	(If outside carporol	e limits, write RU	RAL and give	nearest town	n)
RURAL ond give read		19 MONT	45 XIJAIIA	NITOM	111			
d. NAME OF HOSPITAL	L (If nat in haspital, give stre		d. STREET ADDRESS	V				FARM?
	State Hospit	al					AF2	NO
. NAME OF DECEASED	First	Middle	Last	4. DATE OF	Month	1	Day	Year
(Type or print)	Alpheus	Wilson	Brown	DEATH	Jun	e	II	1960
Male	White	ARRIED NEVER MARRIED DIVORCED DIVORCED		9.	AGE (In years lost buthdoy) yrs.	Months Do		Min.
Oa. USUAL OCCUPATION	(Give kind af wark done 1)	06. KIND OF BUSINESS OR IN	DUSTRY 11. BIRTHPLACE (St	tate ar fareign cau	nigi	12. CITIZEN	OF WHAT	OUNTRY
Dispatcher	-	PANSIT	MARY	LANIN		17 9	S.A.	
3. FATHER'S NAME		PRIVOTA	14. MOTHER'S MAIDE	N NAME			30550	
M1 D.			W	D4 4 43 *= -				
Thomas Br		16. SOCIAL SECURITY NO. 117	7 INFORMANT	Biddles	Addre	155		
	yes, give war or dates of service)	S. SOCIAL SECONITY INC.						
No	//-	NONE	Springfield St	tate Hosp	oital, Syl			
18. CAUSE OF DEAT	H [Enter only one couse per	r line far (o), (b), ond (c).]					INTERVAL BE	DEATH
	WAS CAUSED BY:	rteriosclerotio	c Cardiovascui	lar dises	921		Years	
4-22	DUE TO		J 041 410 1 40 04.				20020	
Conditions, if any							Dame	
gove rise to im	mediate (	ronchopneumonia	a				Days	
couse (o), stoting th	e under-							
lying couse last.	) (c)						1	
5 PART II. OTHE	R SIGNIFICANT CONDITION	S CONTRIBUTING TO DEATH	BUT NOT RELATED TO THE TE	RMINAL DISEASE	CONDITION GIVE	N IN PART I	PERFC	ORMED?
	stad with and	rehral arterio	sclerosis, wit	h nevehot	in mann	44	Vec [	NO .
CBS associ	STGO MITTH CG			II DO LOUD	ALL LEGU	L.L.OF	YES _	
20a. ACCIDENT WAS OR CONTRIBUTING D (IF EITHER, NOTIFY M	UNDERLYING 206. D	DESCRIBE HOW INJURY OCCU	RRED. (Enter nature of injury	in Part I ar Part I	of item 18.)	PTOH	115	
20a. ACCIDENT WAS OR CONTRIBUTING I (IF EITHER, NOTIFY M 20c. TIME OF INJURY	UNDERLYING [] 206. D CAUSE OF DEATH EDICAL EXAMINER)	DESCRIBE HOW INJURY OCCU	RRED. (Enter nature of injury  PLACE OF INJURY (Home, 1)	in Fart Far Part I	of item 18.)	(Cau		(Stote
200. ACCIDENT WAS OR CONTRIBUTING I (IF EITHER, NOTIFY M	UNDERLYING 20b. D CAUSE OF DEATH REDICAL EXAMINER)  Month, Doy, Yeor 20c Wh	DESCRIBE HOW INJURY OCCU	RRED. (Enter nature of injury	in Fart Far Part I	of item 18.)			
20c. ACCIDENT WAS OR CONTRIBUTING I (IF EITHER, NOTIFY M 20c. TIME OF INJURY Hour o. m. p. m.	UNDERLYING 20b. E 20b. E 20c.	DESCRIBE HOW INJURY OCCUI	RRED. (Enter nature of injury  PLACE OF INJURY (Home, 1 foctory, street, office bldg.,	farm, 20f. (City o	r town)	(Cau	inty)	(Stot
20c. ACCIDENT WAS OR CONTRIBUTING E (IF EITHER, NOTIFY M 20c. TIME OF INJURY Hour o. m. p. m. 21. I certify that	UNDERLYING 20 206. E 2 CAUSE OF DEATH EDICAL EXAMINER)  Month, Doy, Year 20 Whot 19 (1) (this haspital) atte	d. INJURY OCCURRED 20e. work of work at work and the deceased framework at the deceased framewor	PLACE OF INJURY (Home, foctory, street, office bldg.,	farm, 20f. (City o etc.)	r town)	(Cau	, that (1) (	(Stot
20a. ACCIDENT WAS OR CONTRIBUTING D (IF EITHER, NOTIFY M  20c. TIME OF INJURY Hour o. m. p. m.  21. I certify that saw the decease	UNDERLYING 20b. E 20b. E 20c.	d. INJURY OCCURRED 20e. work of work at work and the deceased framework at the deceased framewor	RRED. (Enter nature of injury  PLACE OF INJURY (Home, 1 foctory, street, office bldg.,	farm, 20f. (City o etc.)	r town)	(Cau	, that (1) (	(Stot
20c. ACCIDENT WAS OR CONTRIBUTING E (IF EITHER, NOTIFY M 20c. TIME OF INJURY Hour o. m. p. m. 21. I certify that	UNDERLYING 20 206. E 2 CAUSE OF DEATH EDICAL EXAMINER)  Month, Doy, Year 20 Whot 19 (1) (this haspital) atte	d. INJURY OCCURRED 20e. work of work at work and the deceased framework at the deceased framewor	PLACE OF INJURY (Home, to foctory, street, office bldg.,  m. May 3I.  at death accurred at I.	farm, 20f. (City o etc.) 19.60 , ta J	r town)	(Cau	, that (I) (late states	(Stot
20a. ACCIDENT WAS OR CONTRIBUTING D (IF EITHER, NOTIFY M  20c. TIME OF INJURY Hour o. m. p. m.  21. I certify that saw the decease	UNDERLYING 20 206. E 2 CAUSE OF DEATH EDICAL EXAMINER)  Month, Doy, Year 20 Whot 19 (1) (this haspital) atte	d. INJURY OCCURRED 20e. work of work at work and the deceased framework at the deceased framewor	PLACE OF INJURY (Home, foctory, street, office bldg.,	farm, 20f. (City o etc.)	r town)	(Cau ., 19. <b>60</b> d on the d	, that (I) (late states	(Stote
20a. ACCIDENT WAS ON CONTRIBUTING I (IF EITHER, NOTIFY WAS ON THE OF INJURY Hour o. m. p. m.  21. I certify that saw the decease	UNDERLYING 20 206. E 2 CAUSE OF DEATH EDICAL EXAMINER)  Month, Doy, Year 20 Whot 19 (1) (this haspital) atte	a. INJURY OCCURRED 20e. Not while at work 1960, and the	PLACE OF INJURY (Home, foctory, street, office bldg.,  m. May 3I  at death accurred at I	farm, 20f. (City o etc.) 19.60, .ta_J1.354, paraen th	r town)  The Causes and STAFF PHYS.	(Cau , 19.60 d on the d	, that (I) (late stated	(Stote (we) la: d abave b.DATE SIGNE
20a. ACCIDENT WAS OR CONTRIBUTING I (IF EITHER, NOTIFY M  20c. TIME OF INJURY Hour o. m. p. m.  21. I certify that saw the decease 22a. MATTRE  22c. Physician S NAME (Type)	UNDERLYING   20b. E   20b. E	a. INJURY OCCURRED 20e. Not while at work 1960, and the	PLACE OF INJURY (Home, foctory, street, office bldg.,  m. May 3I  at death accurred at I  M.D. PHYS.	farm, 20f. (City o etc.) 19.60, ta J1.354, para the Director Dela State	r town)  The Causes and STAFF PHYS.	(Cau 19.60 d on the d June al,Syk	, that (I) (late stated	(Stoth
20c. ACCIDENT WAS OR CONTRIBUTING E (IF EITHER, NOTIFY M  20c. TIME OF INJURY Hour o. m. p. m.  21. 1 certify that saw the decease 22c. MATURE  22c. PHYSICIAN'S	UNDERLYING   20b. E   20b. E	d. INJURY OCCURRED 20e. Not while at work and the deceased from III_1960, and the	PLACE OF INJURY (Home, foctory, street, office bldg.,  m. May 3I  at death accurred at I  M.D. PHYS.	farm, 20f. (City o etc.) 19.60, ta J1.354, para the Director Dela State	r town)  me II ne causes and STAFF PHYS. 10 Hospit	(Cau 19.60 d on the d June al,Syk	, that (I) (late stated 11,60 esvill	(Stote (we) la:
20a. ACCIDENT WAS OR CONTRIBUTING E (IF EITHER, NOTIFY M  20c. TIME OF INJURY Hour o. m. p. m.  21. I certify that saw the decease 22o. STHATIRE  22c. PHYSICIAN'S NAME (Type)  23a. BURIAL, CREMATION	UNDERLYING   20b. E   20b. E	d. INJURY OCCURRED 20e. Not while at work and the deceased from III_1960, and the	PLACE OF INJURY (Home, foctory, street, office bldg.,  m. May 3I  at death accurred at I  M.D. ATTENDING PHYS.  Y OR CREMATORY  ATTENDING PHYS.	farm, 20f. (City o etc.) 19.60, ta J1.354, para the Director Dela State	r town)  r town)  r town)  re causes and  STAFF PHYS.  Hospit  ON (City, tawn, o	(Cau 19.60 d on the d June al,Syk	inty)  , that (I) (late stated 22  II,60 esvill	(Stote (we) la:

TO HOSPITATE OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 has after death. Page 4 may be not be hospital as after this certificate has been signed by the attending physician and completely filled in by the funeral directar, page 3 shauld be detached for use as the buriol-transit permit. Then please remove carban papers. Pages 1 and 2 should be filed with the State Board of Health priar to burial, cremation, or remayal, and in any event, within 72 haurs after death.

VR A1S (4) 1SM 9/S9

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o. STATE

DIVISION OF STATISTICAL RESEARCH AND RECORDS - BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

MARYLAND

06750

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

b. COUNTY

directar, filed with erol be f fun shou NX puo 2 filled Poges death tely after complet papers. pup pou physician S remave attending pleose the py maval permit hos been signed attending physician.

1. PLACE OF DEATH

o. COUNTY

burial-transit 0 cremoti

that the death certificate

ATTENDING PHYSICIAN: The law requires

certificate

After

FUNERAL DIRECTOR:

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page 3 sh the State 1

by

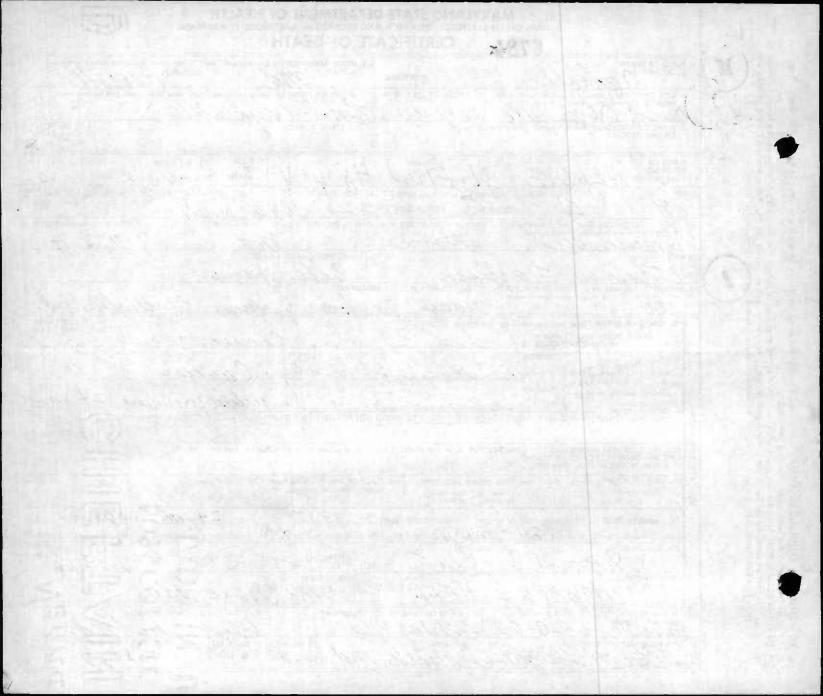
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VR A15 (4) 15M 9/59

22c. PHYSICIAN'S NAME (Type) 23a. BURIAL, CREMATION, MOVAL (Specify)

b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 1b CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town) d. NAME OF HOSPITAL (If not in haspital, give street address) . IS RESIDENCE d. STREET ADDRESS ON A FARM? YES NO NAME OF 4. DATE Middle Month Day DECEASED DEATH (Type or print) 8. DATE OF BIRTH AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED last birthdoy) Months Hours DIVORCED | WIDOWED | yrs. 12 CITIZEN OF WHAT COUNTRY? 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) during prost of working life, even if retired) Tousleve 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME 17. INFORMANT 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. Address 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c). INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o' DUE TO Conditions, if ony, which gave rise to immediate DUE TO couse (a), stating the underlying couse last PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) WAS AUTOPSY PERFORMED? YES NO T 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Port II of item 18.) 20c. TIME OF INJURY Month. Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or tawn) (County) (State) factory, street, office bldg., etc.) Hour o. m. While Not while p. m. of work at work 196 D, that (1) (we) last 21. I certify that (I) (this hospital) offended the deceased from..... ML19 (20, and that death occurred at 71/2 M, from the causes and on the date stated above. saw the deceased, alive on 220. SIGNATURE 22b. DATE SIGNED ATTENDING PHYS. STAFF PHYS. DIRECTOR [ M.D. 22d. ADDRESS esville. 23b. DATE THEREOF LOCATION (City, town, or county) 23c. NAME OF CEMETERY OR CRE (State) 25b. REGISTRAR'S SIGNATUR 25a. REC'D BY REGISTRAR DATE JUN 2 8 60 arthur S. Kinus



TO HOSPIT

VS A15 (4) 1SM 9/SB

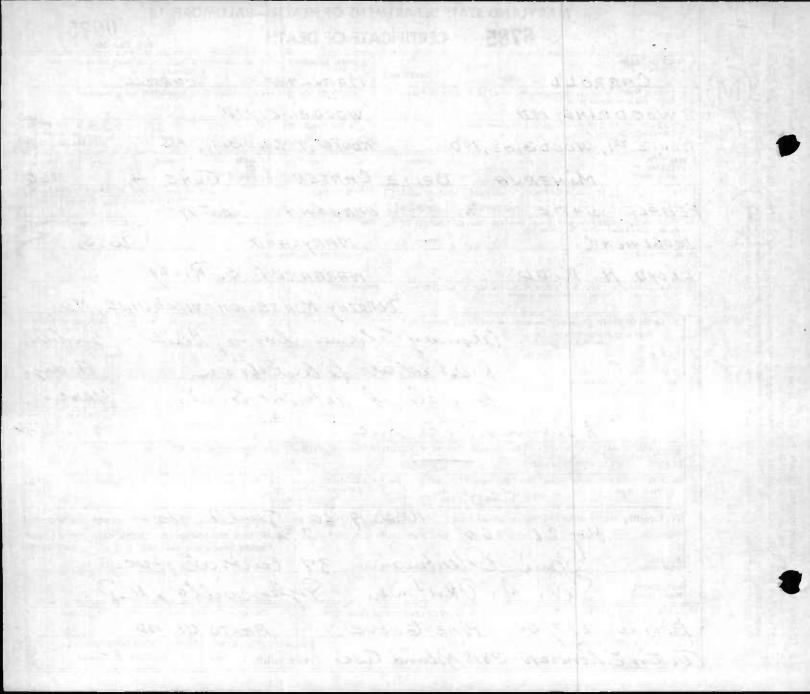
BLACE OF DEATH

### MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

6785 **CERTIFICATE OF DEATH** 

Reg. Dist. No.

a. COUNTY	RROLL	MARYLAND	o. STATE	b. COUNTY	1
b. CITY OR TOWN	V (If outside corporate limits, write	c. LENGTH OF STAY IN 16		If outside corporate limits, write	RURAL ond give nearest town)
RURAL and give	BINE MD.		WOODBIH	E. MD.	
d. NAME OF HOS	SPITAL (If nat in haspital, give street	t address)	d. STREET ADDRESS		e. IS RESIDENCE ON A FARM?
POUTE *	*1, WOODBINE	MD.	ROUTE 1,	NOODBINE, ME	YES NO
3. NAME OF DECEASED (Type or print)	MINERVA.	Middle BELLE	CARTER	4. DATE MO OF DEATH JUNE	nth Day Yeor 1960
5. SEX	6. COLOR OR RACE 7. MAR	RRIED NEVER MARRIED	B. DATE OF BIRTH	9. AGE (In years lost birthdoy)	Months Doys Hours Min.
FEMALE	WHITE WIDOW		UNKHOWH	ABOUT 79 YES	
10a. USUAL OCCUPA during mast of w	ATION (Give kind of work done 10b varking life, even if retired)	. KIND OF BUSINESS OR INDU	ISTRY 11. BIRTHPLACE (Sto	ote or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWO	- 1/	printer, and the same of the s	MARYLA		20,5,
13. FATHER'S NAME			14. MOTHER'S MAIDEN	N NAME	
LLCYD	H. KIDD		MARGAR	ET S. KILI	29
15. WAS DECEASED E	EVER IN U. S. ARMED FORCES? 16  (If yes, give wor or dates of service)		INFORMANT	Ade	fress
			ROTHY KUR	SEVICH - WOO	DBINE, MD,
	DEATH [Enter only one cause per I	line for (o), (b), and (c).]	- /	0 1	INTERVAL BETWEEN
PARI I. C	DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	chancey 1	Wan &	earn, Alley	te Sudden
420	DUE TO	0 10	151	1011	0,
Conditions, if		Huriala	I feler	Capion	9 days
couse (a), statis	ng the under- DUE TO	Generalize	A Arterio	08 decoris	years.
PART II. C	OTHER SIGNIFICANT CONDITIONS	2 / ) / /		RMINAL DISEASE CONDITION GI	VEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED?
OR CONTRIBUTION	WAS UNDERLYING   20b. DES	SCRIBE HOW INJURY OCCURRE	ED. (Enter noture of injury	in Port I or Port II of item 1B.)	
20c. TIME OF INJ Hour o. n p. n	m. While		ACE OF INJURY (Hame, fo ctory, street, office bldg.,	arm, 20f. (City or town)	(Caunty) (State)
21. I certify	that I attended the decea			Trul 4, 196	That I last saw the deceased
alive on	May 26, 19	60, and that death	accurred at 7	M. from the causes a	nd an the date stated above.
	10	OI		ADDRESS (Street, city or town	
ACTUAL SIGNATURE	Dani (	Mutman	M.D. 37	Central 1	que.
PHYSICIAN'S NAME (Type)	Savi A.	OKutma	n. Sy	& sville	, KD.
220. BURIAL, CREMAT	ify) 1/4/12	22c. NAME OF CEMETERY C		22d. LOCATION (City, town,	. 4 %
23. FUNERAL DIRECTO		ADDRESS	VE 240 PE	EC'D BY REGISTRAR 24b. REG	ISTRAR'S SIGNATURE
Tustin	E. Sonoven - 3		ave DATE		Inthus S. Kraua
		1000	DAIL		



DI BOE OF DESTU

### MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 678 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

If 2 STOTIST PROTECTION (Where descreed lived If institution, Peridence before

age age ss.	1"	. COUNTY Carro	011	MARYLAND	* STATE Maryl	and	b. COUNTY Ca	rroll	23.011,
SS - E		b. CITY OR TOWN (if outside cor- write RURAL and give nearest	porate limits, c.	LENGTH OF STAY IN 16	c. CITY OR TOWN (IF		imits, write RURAL and	d give nearest town)	
S P P P P P P P P P P P P P P P P P P P		Westminste	er	1890	X Westm	inster			
à de de		d. NAME OF HOSPITAL OR INST	ITUTION (if not In hospitel,	, give street eddress)	d. STREET ADDRESS			a. IS RESID	
The day		Route 7			Rout	e 7			0 2
Sta Sta	3.	NAME OF DECEASED	First	Middle	Last	4. DATE OF	Month	Day Year	
the the			ALVIN	ROYER	COLEMAN	DEATH	June	8 19 60	)
L 3 th	5.	Male 6. COLOR	OR RACE 7. MARRIED	NEVER MARRIED [ 8.	DATE OF BIRTH		(In years   IF UNDER 1		HRS.
and 2 N			MIDOMED	] DIVORCED	ran 29,1	9/7 10	yrs.		
s aft 2, 2, 1, 2, 399 and and 7,2 1, 2		. USUAL OCCUPATION (Give ki		OF BUSINESS OR INDUSTRY	11. BIRTHPLASE (State o	or foreign country)	12. CIT	IZEN OF WHAT COU	NTRY?
Pas 1	1	FATHER'S NAME	is ful	Calleo	Carn	UCO,	m( - 6	1. S.a.	
Will will will be	1/3	PATHEKS NAME	2 11.0		14. MOTHER'S MAIDEN N	NAME O			
E S FEE S	15	WAS DECEASED EVEN IN ILS A	RMED FORCES?   16. SOC	CIAL SECURITY NO.   17. IN	VEORMANIE CL	- Mar	Address		-
with 18.	(Y	s, no or unkown) (Ifyesgivewar	or datas of service)	-07-438/2	00 1.0.		a Atm	1 2 101	9.74.
tem tem with with perr	-	18. CAUSE OF DEATH Enla	ronly one cadso per line for	or (a), (b), and (c),	oce it itsees	may b	million	I INTERVAL BETWEE	EN EN
in l in l in l in l in l	1	PART I. DEATH WAS CAU	SED BY: Corror	nary occlusion	n			ONSET AND DEAT	TH
and and		IMMEDIATE (	DUE TO						
ffic ffic val		Conditions, if any, which		riosclerotic	heart diseas	6			
short	1	gava rise to immediata cause	DUE TO	10001010010	MONTO GIDCED				
as as	18	(a), stating the underlying cause last.	(c)						
"De use	Z	PART II. OTHER SIGNIFICAN	T CONDITIONS CONTRIB	UTING TO DEATH BUT NOT	RELATED TO THE TERMIN	AL DISEASE COND	ITION GIVEN IN PART		
S Condraine The	NATION N							YES X NO	
ould cre	CERTIFICATION	20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING	20b. DESCRIBE H	IOW INJURY OCCURED. (En	ter nature of injury In Part	I or Part II of item 1	8.)		
ER:		CAUSE OF DEATH.							
MIN Chie	WEDICAL	20c. TIME OF INJURY Month	h, Day, Year   20d. INJU While		E OF INJURY (Home, farm, ry, street, offica bldg., etc.)	20f. (City or to	wn) (Cou	nty) (Stat	te)
XA. web. web. web. web. web. web. web. web	ME	p.m.	19 at work	at work					
D to the prince		21. I certify that I took	charge of the remains	s described above, held	d an Autopsy X, I	nspection,	Inquiry	and in my opini	ion
CA ded ded ded ded ded ded ded ded ded de		death resulted from: N	atural causes X,	Accident Suicid			mined manner		
war war JRI Jag		- Amiray	1.100	M	CHIEF MEDICAL EX				
M for the t		SIGNATURE	0000		M,D,	CAL EXAMINER		6/8/60	
xecu be Sign		EXAMINER'S NAME (Type)	M Drod	low King In	DEPUTY MEDICAL	Immed		0/0/0	0
DEPUSASS executed be FUNERA its design	222			ley King, Jr.			) City, town, or country	) (Stete)	
0 4	1	REMOVAL (Specify)	11/10 /2	Vitariot.	Comola	1110-	tan " 7	- mad	/
HH	23	EUNERAL DIRECTOR	160 16	ADDRESS	240. AEC'	D EY KEGISTRAR I	24b. REGISTRAR'S SI	IGNATURE	•
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### MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH CHOM

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o. COUNTY CARROLL	MARYLAND	2. USUAL RESIDENCE DWD o. STATE MARY LA	b. COUNTY	TCOMERY (Scion)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 16	c. CITY OR TOWN (IF o	utside corporate limits, write RURAL or G	nd give nearest town) 1530.2
d. NAME OF HOSPITAL (If not in hospital, give street of OR INSTITUTION SPRING FIELD STATE H OS	oddress)	d. STREET ADDRESS 7 29 ARGYYL	E ROAD	e. IS RESIDENCE ON A FARM? YES NO
NAME OF DECEASED (Type or print) FLORENCE JU	Middle UTLIA	COOPER	4. DATE Month OF DEATH JUNE	Day Year 1960
SEX 6. COLOR OR RACE 7. MARR WIDOWE	IED NEVER MARRIED DIVORCED DIVORCED	8. DATE OF BIRTH 11-2-86	9. AGE (In yeors IF UNIT Month yrs.	DER 1 YEAR IF UNDER 24 HR ns Days Hours Min.
during most of working life, eyen if retired)  Wursche Housekeeper & Ch	KIND OF BUSINESS OR INDU	STRY 11. BIRTHPLACE (Stote NEW Y O		U.S. A.
B. FADER'S NAME Daniel Schu ler		14. MOTHER'S MAIDEN N	h McMichael	
for me as well-made and the state of control of		enk j. Coopen	, 729 Argyle Road	,Silver Sprin
Conditions, if ony, which gove rise to immediate couse (o), stoting the under-lying couse lost.	ction of myoca ronary thrombo . C.V.Disease	s is with arterial		years
PART II. OTHER SIGNIFICANT CONDITIONS CO. ACCIDENT WAS UNDERLYING TO 206. DESCOR CONTRIBUTING ED CAUSE OF DEATH				PART 1(o) 19. WAS AUTOPS PERFORMED? YES NO
(IF EITHER, NOTIFY MEDICAL EXAMINER)	NJURY OCCURRED 20e. PL	ACE OF INJURY (Home, form ctory, street, office bldg., etc.	, 20f. (City or town)	(County) (Sto
21. I certify that (I) (this hospital) attends aw the deceased alive an 220. SIGNATURE	alus	death accurred at	M, fram the causes and an	the date stated abave 122b. DATE SIGN
22c. PHYSICIAN'S NAME (Type) HEINZ H. KL	AATSCH 19. D	22d. ADDRESS SPRINGFIE		
REMATION 6/4/60	FT. LINCOLN C	REMATORY	PRINCE GEO. COUN	NTY, MARYLAND
FUNERAL DIRECTOR'S SIGNATURE Y INC.	ADDRESS SPR	ING, MD. 250. REC'	D BY REGISTRAR 256, REGISTRAR'S	

the funeral director, TO HOSPIT RATENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haven be referred by the haspital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in bipage 3 should be detached for use as the buriot-transit permit. Then please remave carbon papers. Pages 1 and the State Board of Health prior to burial, cremation, ar removal, and in any event, within 72 purs after death.

offer death. Page 4

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

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5788	CERTIFICAT	E OI DEAIII		
PLACE OF DEATH o. COUNTY Carroll	MARYLAND	2. USUAL RESIDENCE (Whe	d b. COUNTY Ans	sidence before admission) ne Arundel
b. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 16	c. CITY OR TOWN (If ou	utside corporate limits, write RURAL	00.0
Sykesyille	lyr. 8mos. 9dy.	. West A	nnapolis	Od 10.2
d. NAME OF HOSPITAL (If not in hospital, give street or INSTITUTION	oddress)	d. STREET ADDRESS		e. IS RESIDENCE ON A FARM?
Springfield State Hosp	ital	110 Forb	es Street	YES NO
NAME OF First DECEASED	Middle	Last	4. DATE Month	Day Year
(Type or print) William		Davis	DEATH June	19 1960
6. COLOR OR RACE 7. MARR WIDOWE		ne 15, 1904	9. AGE (In years lear birthday) yrs.	ths Days Hours Min.
Oa. USUAL OCCUPATION (Give kind of work done 10b. during most of working life, even if retired)	KIND OF BUSINESS OR INDUST	RY 11. BIRTHPLACE (State of	or foreign country) 12	CITIZEN OF WHAT COUNTRY
Carpenter		Maryla	nd	U.S.A.
3. FATHER'S NAME		14. MOTHER'S MAIDEN N.		
William Davis		Lola	Blanche Ward	
5. WAS DECEASED EVER IN U. S. ARMED FORCES? 16.	SOCIAL SECURITY NO. 17. INF	FORMANT	Address	
(Yes, no. or Unknown) . (If yes give war or dates of service)		ringfield Hos	pital Records, Sy	ykesville, Md.
18. CAUSE OF DEATH [Enter only one couse per line PART I. DEATH WAS CAUSED BY:	ne far (o), (b), and (c).]  Arcinoma of medi			INTERVAL BETWEEN
Canditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  PART II. OTHER SIGNIFICANT CONDITIONS C Schizophrenic Reaction,	CONTRIBUTING TO DEATH BUT N	NOT RELATED TO THE TERMIN Pulmonary Tu	NAL DISEASE CONDITION GIVEN IN	PERFORMED?
	CRIBE HOW INJURY OCCURRED.		art I or Part II of item 18.)	YES NO
	Nat while facts	CE OF INJURY (Home, form, ory, street, office bldg., etc.)	20f. (City or town)	(County) (Stat
21. I certify that (I) (this haspital) attends saw the deceased alive an June 19	ded the deceased fram 00		58 ta June 19 10 M, fram the causes and an	
220 SIGNATURE 120 S. Mar	igthe "	ATTENDING ME PHYS. DIR	D. STAFF Ju	ne 19, 1960 IGN
NAME (Type) Ellis S. Margolin	M.D.		State Hospital,	Sykesville,
30. BURIAL, CREMATION, 23b. DATE THEREOF	HILLCREST OF	Memorial	23d. LOPATION (City, town, or cause	lio MR
FUNERAL DIRECTOR'S SIGNATURE  John M. Janka Suns	annapole	one	D BY REGISTRAR 25b. REGISTRAR UN 22'60 and	'S SIGNATURE

TO HOSPIT R ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 har pifer death. Page 4 may be reformed by the hospital ar ottending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shauld be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shauld be filled with the State Board of Health prior to burial, cremation, ar remayal, and in any eyekt, within 72 hours often death.

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# MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

OCHEE

	678.	CERTIFIC	ATE OF D	EATH		(10)	00	12.0
1. PLACE OF DEATH o. COUNTY	Carroll	MARYLAN	II a STATE	IDENCE (Where dece	ased lived. If institut b. COUNTY		e before ode	/
b. CITY OR TOWN RURAL and give	(If outside corporate limits, w	rite c. LENGTH OF STAY IN 1	c. CITY OR	TOWN (If outside co	arporate limits, write f	RURAL and gi	ve nearest to	own)
KOKAL ONG GIVE	Henryton	221 days		Rhodesd	ale	(	09X	-2
d. NAME OF HOSP OR INSTITUTION		tate Hospital	d. STREET	ADDRESS			e. IS ON YES	RESIDENCE A FARM
NAME OF DECEASED	First	Middle	lo	4. DAT	TE Moi		Day	Year
(Type or print)	Samuel	Irvin		ckins DEA	0 0310	-	16	1960
5. SEX Male		MARRIED NEVER MARRIED DOWED DIVORCED		, 1891	9. AGE (In years last birthday) 60 yrs.		Days Hou	1
during most of wo	rking life, even if retired)	106. KIND OF BUSINESS OR IN			jn cauntry)		EN OF WHA	
Unemp	Loyed			aryland			U.S.	A.
13. FATHER'S NAME	Steve Dockin	ns	14. MOTHER	S MAIDEN NAME	da Farrar			
5. WAS DECEASED EN	ER IN U. S. ARMED FORCES?	16. SOCIAL SECURITY NO. 17	, INFORMANT			dress		
No	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	None	Samuel I.	. Dockins	-Pt. Rho	desda.	le, M	aryla
gove rise to cause (o), statin lying couse last	g the under- DUE TO (c)	Far advanc				VEN IN PART	1(a) 19. W	AS AUTOPS
PART II. O  20g. ACCIDENT V  OR CONTRIBUTIN (IF EITHER, NOTIF	VAS UNDERLYING 206 G CAUSE OF DEATH Y MEDICAL EXAMINER)	. DESCRIBE HOW INJURY OCCU	RRED. (Enter nature	af injury in Port I or	Port II of item 18.)			□ NO [
20c. TIME OF INJU Hour o. m p. m	. 10	20d. INJURY OCCURRED 20e. While Not while t work ot work	PLACE OF INJURY foctory, street, office		(City ar town)	(Co	ounty)	(Sto
saw the dece	ased alive an Jun	ttended the deceased fra e 16 19 60, and the	Nov.,		om the causes a		O, that (I date stat	) (we) lo
	dyars M. Ma	mlaney	M.D. ATTENDIN	DIRECTOR	STAFF PHYS.		6	226. DATE -16-6
22c. PHYSICIAN'S NAME (Type)		M. Maculans, S		enryton,	Maryland			
REMOVAL (Specification)	12/6/21/1960		· andrasas.	7 236-10	CATION (City, town, OPCHEG	ter (	Co.,"	State) //
24. FUNERAL DIRECTO	R'S AGRINTURE	A Combri	des Md	DATE JUN 2 0	000	ISTRAR'S SIG	NATURE PURCHA	

TO HOSPIT. R ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 has after death. Page 4 may be removed by the haspital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, ar removal, and in any event, within 2 hours after death. VR A15 (4) 15M 9/59

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	OBSIZED				
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baniwack , sinbeot	and T. Beckins Pt. Bho	None:			
	- Yourtal'theat us	Impurior head			
	asilostan	re Vermonte			
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	of mark a Pour Street				
00-05-0	all the same				
	to Ferryton, Karshant	Racelanie, Eg	er Sagara		
PW 1970					

P. .

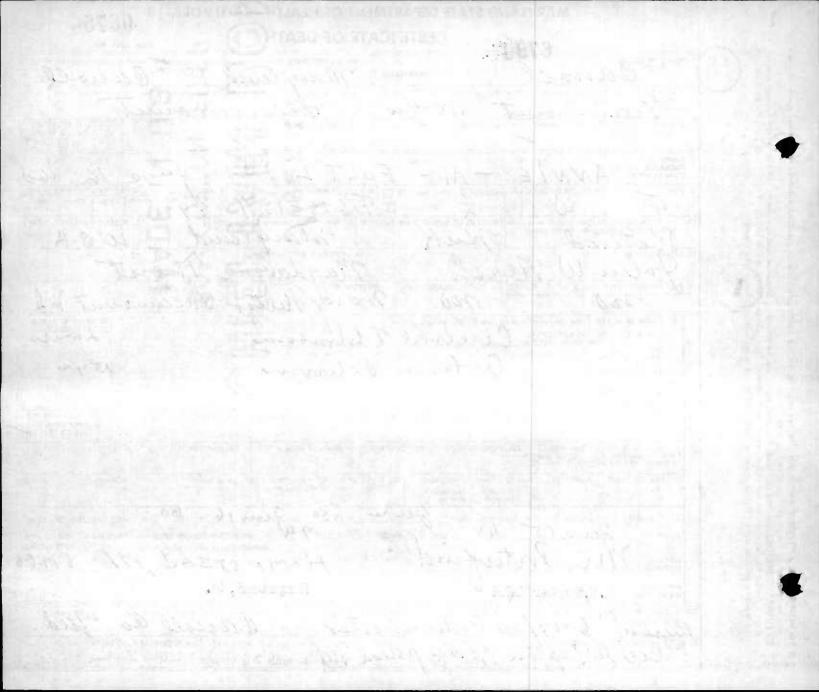
VS A15 (4) 15M 9/58

### MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

06756

6790 CERTIF	ICAIE OF DEATH	Reg. Dist. No.
1. PLACE OF DEATH O. COUNTY COUNTY MARYL	CASTATE	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  Cleumocult  So 4/1	N 1b c. CITY OR TOWN (If outside corporate of the corpora	prote limits, write RURAL ond give nearest town)
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES NO
3. NAME OF DECEASED (Type or print) ANNIE — Middle	FOLTZ 4. DATE OF DEATH	Month Day Year 1960
5. SEX  6. COLOR OR RACE  7. MARRIED NEVER MARRIED DIVORCED	- 611 A ne 1041	9. AGE (In years lost birthdoy)  yrs. IF UNDER 1 YEAR IF UNDER 24 HRS.  Manths Doys Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during host of working life, even if retired)	INDUSTRY 11. BIRTHPLACE (State or foreign of Manyle	country) 12. CITIZEN OF WHAT COUNTRY?
Folie W Hersh	Malf delen	2 Therit
15. MAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes: no. or unknown) (It yes, give wor or dates of service)	Harry Halty	Geleuwout Md
18. CAUSE OF DEATH [Enter only one couse per line far (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (c)	Thombosis	INTERVAL BETWEEN ONSET AND DEATH
Canditions, if ony, which)  (b)  Outerry	- Achrosis	1546.
gove rise to immediate cause (a), stating the <u>under-lying couse last.</u> DUE TO  (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEAT	TH BUT NOT RELATED TO THE TERMINAL DISEAS	SE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES NO 1
CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	CURRED. (Enter nature of injury in Port I or Po	rt II of item 18.)
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 2 Hour o. m. While Not while at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, affice bldg., etc.)	y or town) (Caunty) (State)
21. I certify that I attended the deceased fram. And that a	death accurred at 7 4 M. fram	the course and an the date stated above
ACTUAL SIGNATURE M.C. Ontrofend		the causes and an the date stated above parts signed, city or town state)  DATE SIGNED  TEAL  11-6
PHYSICIAN'S M. G. Porterfield	Hampstead,	Mdo
220. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMET PRIMOVALLISPECIFY 6-19/60 MULLIC	TERY OR CREMATORY 22d. LOCA	TION (City, town, or coupy)
23. PUNTRACIDIRECTOR'S SIGNATURE HADDRESS HAULELAN	tead Up DATELLIN 2 0 '6	. 0 11

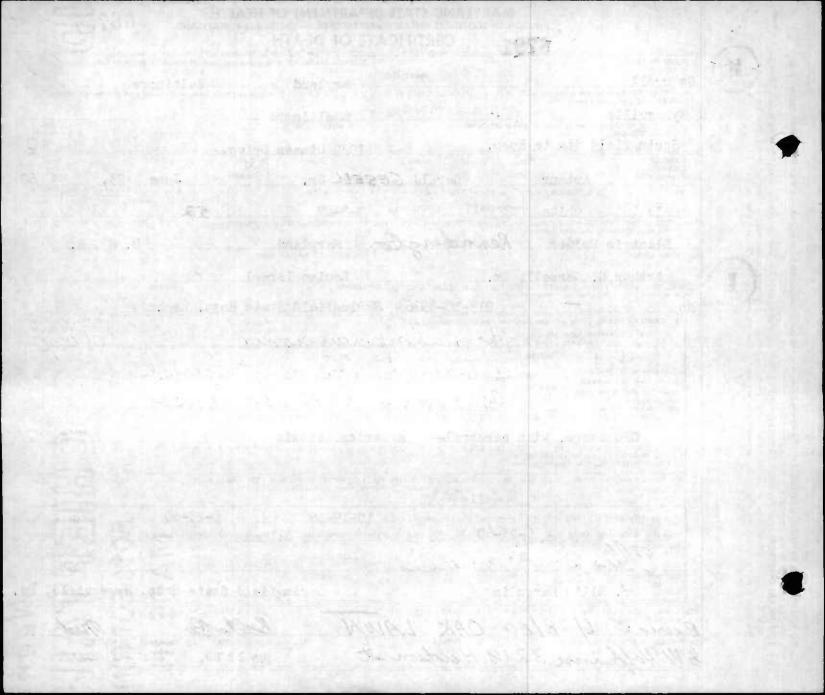


VR A1S (4) 1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06757

	Thomas a Palma	266 7 5 60		
1. PLACE OF DEATH o. COUNTY	AAADVI AND	2. USUAL RESIDENCE (W	here deceased lived. If institution b. COUNTY	
Ca rroll	MARYLAND	Maryland	Baltin	
b. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b		autside corporate limits, write R	
Svkesville	8 Mos.6 days	R altimor	9	02X-d
d. NAME OF HOSPITAL (If not in haspitat, give street of OR INSTITUTION	address)	B altimor d. STREET ADDRESS		e. IS RESIDENCE ON A FARM?
Springfield Sta te Hosp.		1939 Dineen	Drive.	YES NO
3. NAME OF First DECEASED (Type or print) Arthur	Middle Gerald GE:	Last	4. DATE Mon OF DEATH JUY	
S. SEX 6. COLOR OR RACE 7. MARR		B. DATE OF BIRTH	9. AGE (In years	IF UNDER 1 YEAR IF UNDER 24 HRS.
Male white WIDOWE		9-3-07	lost birthday)	Months Days Hours Min.
Oa. USUAL OCCUPATION (Give kind of work done 10b.	KIND OF BUSINESS OR INDUS		ar foreign cauntry)	12. CITIZEN OF WHAT COUNTRY?
during mast of working life, even if retired)  Electric Welder	anohera Por	Maryland		U.S.A.
13. FATHER'S NAME	Nice of Co	14. MOTHER'S MAIDEN	NAME	
Amthum C Connell Cm		Tourism To	ma a l	
S. WAS DECEASED EVER IN U. S. ARMED FORCES? 16.	SOCIAL SECURITY NO. 17. IN	Louise Is	Add	ress
(Yes, no, or unknown) (If yes, give war or dates of service)	72 70 6226 6	nminafiald C	tota Waan Page	and a
		Dilugitera 2	tate Hosp. Reco	INTERVAL BETWEEN
1B. CAUSE OF DEATH [Enter only one couse per lin	ie for (a), (b), and (c).			ONSET AND DEATH
IMMEDIATE CAUSE (o)	renchot	MOUNT	nea	alley0
DUE TO	1. /1	1 1	1/	
Conditions, if any, which ) (b)	Corus	rote fel	art allego	
gave rise to immediate cause (a), stating the under		10.	0	
lying cause last. (c)	ronary	arxeri	Bel Lens	D
PART II. OTHER SIGNIFICANT CONDITIONS C	CONTRIBUTING TO DEATH BUT	NOT RELATED TO THE TERM	AINAL DISEASE CONDITION GIV	VEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED?
CBS Assoc. with cer		riosclerosis		YES NO
PART II. OTHER SIGNIFICANT CONDITIONS C  CBS Assoc. with cer  200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING OF CAUSE OF DEATH  (IF EITHER, NOTIFY MEDICAL EXAMINER)	CRIBÉ HOW INJURY OCCURRED	). (Enter nature of injury in	Part   or Part    of item    IB.)	
		ACE OF INJURY (Home, for		(County) (State)
Hour o. m. While at war!	Not while	tary, street, affice bldg., e	(c.)	
	<u> </u>	10 10 50	6-25-60	10 (1) (1) (1) (1)
21. I certify that (I) (this haspital) attend				
saw the deceased alive an 6-25-6	10 19, and that d	eath accurred at 6.1	1 Markom the causes or	an the date stated above
The S. Ma	ratten		MED. STAFF PHYS.	6-21-60 SIGNED
22c. PHYSICIAN'S NAME (Type) Dr. Ellis Margolin		22d. ADDRESS	field State Ho	sp, Sykesville, M
	/			
230. BURIAL, CREMATION, 23b. PATE THEREOF REMOVAL (Specify)  BURIAL BURIAL  BU	OAK LAL	UN	Balto-Cer	ar county) (State)
24. FUNERAL DIRECTOR'S SIGNATURE	APDRESS	250. REG	D BY REGISTRAR 25b. REGI	STRAR'S SIGNATURE
2.91. Holhum 3218	Hudson &	DATE	JUN 2 8 '60	arthur S. Krous



VR A1S (4) 1SM 9/59

Item	18	Film	274	11-1 MARYLAND STATE DEPARTMENT OF HEALTH
				DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
				CERTIFICATE OF DEATH

DIVISION OF	STATISTICAL RESEARCH AND RECORDS — BALTIMORE
5792	CERTIFICATE OF DEATH

-	()	6	7	5	8
		-	. 0	0	- 1

-			4								
	Caunty Ca	rroll		MARYL		usual RESIDENCE (W		lived. If institution b. COUNTY		ce before od	1
	RURAL and give ne		ts, write	c. LENGTH OF STAY IN		c. CITY OR TOWN (IF		ate limits, write RI	URAL and	give nearest	tawn)
	Sykesvill  d. NAME OF HOSPIT. OR INSTITUTION	E AL (If nat in haspital, g	ive street	ddress)	3	d. STREET ADDRESS	е		-		RESIDENCE N A FARM?
	Springfie	ld State	Hospi	ital		1703 Ali	ceanna	Street		YES	S NO R
	NAME OF DECEASED (Type or print)	Will		Middle		Gessler	4. DATE OF DEATH	Mon June		Day	Year 19 60
S. 5	SEX	6. COLOR OR RACE	7. MARI	RIED NEVER MARRIED	B. C	DATE OF BIRTH		9. AGE (In years last birthday)	IF UNDER	1 YEAR IF U	INDER 24 HRS.
	Male	White	WIDOW	ED DIVORCED	KI S	Sept. 11, 1	902	57 yrs.	Manns	Days Ho	min.
10a	. USUAL OCCUPATIO during most of wark Oiler	N (Give kind af wark ing life, even if retired	dane 10b.	KIND OF BUSINESS OR	INDUSTRY	Maryla:		untry)	12.CITI	U.S.A	AT COUNTRY?
13.	FATHER'S NAME				1	4. MOTHER'S MAIDEN	NAME				- 10
	George Ge	ssler				Ella	Fin				
1S. (Ye	WAS DECEASED EVEL	R IN U. S. ARMED FOR		SOCIAL SECURITY NO.	17. INFO			Add			
	NO NO	***		-	Spi	ringfield H	ospital	Records	3		
	PART I. DEA	nmediate (	1.	Ymonary/ Lube Arterioscl Late laten	erot	ic cardiov				ONSEL	ears.
CERTIFICATION	C.B.S. ass		/	CONTRIBUTING TO DEAL CONOLLSM, W		**	ainal disease eaction	CONDITION GIV	'EN IN PAR	T 1(a) 19. W	AS AUTOPSY ERFORMED?
	20a. ACCIDENT WA OR CONTRIBUTING (IF EITHER, NOTIFY	S UNDERLYING  CAUSE OF DEATH MEDICAL EXAMINER)	20b. DES	CRIBE HOW INJURY OC	CURRED. (	Enter nature af injury in	Port I or Port	Il of item 1B.)			
MEDICAL	20c. TIME OF INJUR Haur o. m. p. m.	Y Month, Day, Ye	20d. 1 While at war	Nat while		OF INJURY IHame, far y, street, office bldg., et		ar tawn)	(0	Caunty)	(Stote)
	saw the deceos		) attend	ded the deceased f		th occurred at 10					ited obove.
	22a. SIGNATURE	is di	m	eighten	M.C	PHYS.	MED.	STAFF PHYS.		6	226. DATE SIGNED 20/60
	22c. PHISICIAN'S NAME (Type)	Ellis S. M	argol	Lin, M.D.		22d. ADDRESS					~~~~
230	BURIAL CREMATIO	N. 126. DATE THEREO	196	236. NAME OF CEME	TERY OR C	My on the	23d. LOCAT	Ball	or county)	711	(State)
24.	FUNERAL DIRECTOR	S SHONATURE	nell	AODRESS	ille	DATE DATE	UN 2 7 '6	0	STRAR'S SI		

Brees, 27deye And the property of the property of the self-of-Committee of the contract of t ALMERICA SE LE PASSIFICIO

## FOR STATE HEALTH DEPT.

TO DEPUTY WEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay precessary, please execute execute shifticate, writing the ward "pending" in pendi in Item, 18. Give Pages 1, 2, and 3 to the fundification. Page 4 should 6. forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Baard of Health, are its designated agent, prior to burial, cremation, ar removal, and in any event within 72 hours after death.

VS. ATSME 5M 2/57

### MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 6793 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06759

	0110					Keg, Dist. N	10.	
1. PLACE OF DEATH	77	MARYLAN	2. USUAL RESIDENCE (			ion: Residence b		ission)
	erroll  outside corporate limits, write RUI							
and give nearest town	)		c. CITY OR TOWN (I		itiniis, write r	OKAL ond give	neorest ter	wii)
Sykesvil		17 days	d. STREET ADDRESS	la		0/	000	ESIDENCE
	eld State Hos	ot in hospitot, give street address)	325 Willia	ms Street			ON	A FARM?
3. NAME OF	First	Middle	Lost	4. DATE	Month	Do		(ear
(Type or print)	James Juni	lor Hamilton		OF _	une 9	,	,	9 60
5. SEX	6. COLOR OR RACE 7.	MARRIED NEVER MARRIED	B. DATE OF BIRTH	9. AG	hinth day 1	IF UNDER TYEA	-	-
male	white w	DIVORCED T	1-29- 21		9 yrs.	Months Days	Hours	Min.
during most of working Accounting	ig life, even if retired)	e 10b. KIND OF BUSINESS OR INDU	STRY 11. BIRTHPLACE (Stoke Maryland	Carrell and		U.S.		COUNTRY
13. FATHER'S NAME			14. MOTHER'S MAIDEN	NAME	111-01			
James H.	Hamilton		Bertie Mar	garet Tay	lor			
15. WAS DECEASED EV	ER IN U. S. ARMED FORCE		INFORMANT		Address		7.15	
yes	1942-45	" 214-12-3809	Hospital rec	ords				
	TH Enter only one couse p	per line for (o), (b), and (c).	7				TERVAL BETWE	
PART I. DEA	TH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO	Suffocation by	hanging		- 7	ON	ISET AND DEA	ATH
Conditions, if o gove rise to immed (o), slating the couse last.	diole couse							
PART II. OTH		ONS CONTRIBUTING TO DEATH BU			DITION GIVE	N IN PART 1(0)		
Schizo	phrenic react	tion, chronic und	ifferentiated	type			YES	RMED?
PART II. OTH Schizo  200. EXTERNAL CAI PRIMARY 12 or COI CAUSE OF DEATH.	USE WAS NTRIBUTING () 206. C	DESCRIBE HOW INJURY OCCURRED.  By hanging	(Enter nature of injury in Po	rt I or Port II of item	n 18.)			
~	RY Month, Doy, Year 6-9-60	20d. INJURY OCCURRED 20e. P While of work of work Hos	ACE OF INJURY (Home, for octory, street, office bldg., etc pital grounds	m. 20f. (City or tow	lle, C	(County)	Md.	(Stote)
21. I certify th	hat I took charge of	f the remains described ob	ove, held an Autop	sy . Inspec	tion 🖺,	Inquiry X	, on	d in my
opinion death	resulted from: Nat	turol causes . Accident	, Suicide ,	Homicide	Undeter	mined monr	ier 🗌	
ACTUAL (	1 9	norch	CHIEF MEDICAL E	YAMINER []			DATE S	SIGNED
SIGNATURE	aury C.	100100	M.D. CHIEF MEDICAL E				6-9-6	60
EXAMINER'S J.	ames T. Marsh	h	DEPUTY MEDICAL				0-9-0	50
220. BURIAL, CREMATIC REMOVAL (Specify)	June 12,	22c. NAME OF CEMETERY C 1960 Mt. Herman		Allegan			rylar	
23. FUNERAL DIRECTOR	S SIGNATURE Hafer	address Cumberland	DATE	D BY REGISTRAR		TRAR'S SIGNATI		
U	//			11 10 00	Ciri	hur S. Has	wa	

March   Marc		ER'S CHRESPORTE OF DEATH			
			- 14 Y	and the second second	
				TRANSPORT OF THE PARTY OF THE P	
			Secretary Co. Epitosom		
				AND MARKET STATES	
		THE RESIDENCE OF THE PARTY OF			
			I make the second	A CONTRACTOR OF THE PARTY OF TH	
				MALEST STORY OF THE STATE OF	
				er e's all amount	
	BE THE TO				
	Aldred A. Lance and Co.				

CEDTIEIC ATE OF DEATH

06760

Serving field State Hospital.    Myersille, Maryland.   On A Fast		0/94 CERTIFICAT	L OI DEATH
RURAL and give morest lown  Syrics 111e  d. NAME OF HOSPITAL (II not in hospital, give street address)  of Hospital (II not in hospital, give street address)  of Hospital (II not in hospital, give street address)  of Hospital (II not in hospital)  3. NAME OF HOSPITAL (II not in hospital)  5. SEX  4. OLOR PACE  4. DATE ORAH  5. SEX  4. OLOR PACE  4. DATE ORAH  5. NAME  4. DATE ORAH  5. PACE (In year)  6. OLOR PACE  6. OLOR PACE  6. OLOR PACE  7. NARRIED  10. NOTICES AND OF BUSINESS OR INDUSTRY  11. BIRTHACK (Stole or foreign country)  12. CHIZEN OF WHAT COUNT  Charlotte  Charlotte  Charlotte  Charlotte  Charlotte  Routzahm  13. FATHEYS NAME  Thaddeus Hauver  14. NOTICES NAIDEN NAME  Charlotte  Charlotte  Charlotte  Charlotte  Charlotte  Routzahm  15. WAS DECEASEDEVER IN U. S. ARMED FORCES? [16. SOCIAL SECURITY NO.   17. INFORMANT  Test  18. CAUSE OF DEATH [Enter only one couse per fine for (a), (b), and (c)-]  PART I. DEATH WAS CAUSED BY:  18. CAUSE OF DEATH [Enter only one couse per fine for (a), (b), and (c)-]  18. CAUSE OF DEATH [Enter only one couse per fine for (a), (b), and (c)-]  19. OLOR PACE IN JURY (II) (II) (II) (II) (II) (II) (II) (II	1.	a COUNTY Commol 1	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick 125
A STREET ADDRESS OF INSTITUTION OF I		RURAL and give nearest town)	
Decade   Decade   Decade   Decade   Course   Decade   D		d. NAME OF HOSPITAL (If nat in haspital, give street address) OR INSTITUTION	d. STREET ADDRESS e. IS RESIDENCE
Male White WIDOWEID DIVORCED 3-2-1886 74 yrs. Months Days Mours IN The Country of		DECEASED LITER TO THE COMPANY THE COMPANY TO THE COMPANY TO THE COMPANY TO THE COMPANY TO THE CO	Unament OF 6
School sharpland  U.S.A.  13. FATHER'S NAME  Thaddeus Hauver  15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT  Tes University of the first of the district	5.	Mal-	lost highlight land land land land
Thaddeus Hauver    S. WAS DECEASEDEYER IN U. S. ARBED SCRESS   16. SOCIAL SECURITY NO.   17. INFORMANT   Address   Address   Co. or unknown   17. INFORMANT   Address   Address	10c	usual occupation (Give kind of work done 10b. KIND OF BUSINESS OR INDUS: during most of working life, even if refired ) Fred.Co.Scho	
TS. WAS DECEASEDEVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT  TO UNITED A COLUMN OF THE PROPERTY OF THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 (a) 19. WAS AUTO OR COURSE (b). THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 (b) 19. WAS AUTO OR CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 (c) 19. WAS AUTO OR CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 (c) 19. WAS AUTO OR CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 (c) 19. WAS AUTO OR CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 (c) 19. WAS AUTO OR CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 (c) 19. WAS AUTO OR CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 (c) 19. WAS AUTO OR CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 (c) 19. WAS AUTO OR CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 (c) 19. WAS AUTO OR CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 (c) 19. WAS AUTO OR CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 (c) 19. WAS AUTO OR CONTRIBUTION OR CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 (c) 19. WAS AUTO OR CONTRIBUTION OR CONTRIBUTED OR CONTRIBUTION OR CONTRIBUTION OR CONTRIBUTION OR CONTRIBUTION OR CONTRIBUTION OR CONTRIBUTED OR CONTRIBUTION OR CONTRIBUTED	13.		
Tes   If the only one couse per line for (a), (b), and (c).	L	Thaddeus Hauver	Charlotte Routzahnn
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  DUE TO  Conditions, if ony, which gave rise to immediate cause (b).  Use TO  Conditions, if ony, which gave rise to immediate cause (c). stating the under lying couse last.  (c)  C. D. S. I. S. S. With Cerebral arterhoscierosis, with psychotic reaction  PREMOVAL FUNDAMENTAL CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTO PREPARED TO CONTRIBUTING COURSE (a). ACCIDENT WAS UNDERLYING CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTO PREPARED TO CONTRIBUTING COURSE (a). DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of idem 18.)  OR CONTRIBUTING ACUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED while of work of wor	{Ye	ss, no, or unknown) (If yes, give war or dates of service)	
20a. ACCIDENT WAS UNDERLYING  20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Parl II of item 1B.)  20a. ACCIDENT WAS UNDERLYING  20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Parl II of item 1B.)  20c. TIME OF INJURY Manth, Day, Year Hour a.m.  19  20d. INJURY OCCURRED at work  20d. INJURY OCCURRED factory, street, affice bldg., etc.) 21  1 certify that (I) (this haspital) attended the deceased fram 5-18 - 19  50, ta6-5  1960, that (I) (we) saw the deceased alive an 6-5- 1960, and that death accurred of 50M, fram the causes and an the date stated about 22a. SIGNATURE  22a. SIGNATURE  22b. DA ATTENDING MED. STAFF SIGNATURE  23a. BURIAL, CREMATION. 23b. DATE THEREOF St. Paul S Lutheran Myersville, Tred. Co. Md. 24. FUMERAL DIRECTOR'S SIGNATURE  23a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)  DUE TO  Conditions, if ony, which gave rise to immediate cause (a), stating the under-	QNSET AND DEATH
OR CONTRIBUTING CAUSE OF DEATH  (IF EITHER, NOTIFY MEDICAL EXAMINER)  20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED While at work at work at work at work at work 21 I certify that (I) (this haspital) attended the deceased fram 5-18 - 19 50, ta 6-5 19 60, that (I) (we) saw the deceased alive an 6-5- 19 60, and that death accurred at 25 3M, fram the causes and an the date stated about 22c. Physician's NAME (Type Agustin del Campo M.D.  23a. BURIAL, CREMATION. 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, tawn, or county) (State) Pred Co Md. 22f. Functions of the production of the	ICATION		YES NO
Hour a. m.  19   White   Not white   factory, street, affice bldg., etc.)    21. I certify that (I) (this haspital) attended the deceased fram. 5-18 - 19   19   19   19   19   19   19   19	AL CERTIF	OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
saw the deceased alive an 6-5- 19 60, and that death accurred a 53M, fram the causes and an the date stated ab 220. SIGNATURE  220. SIGNATURE  221. PHYSICIAN'S NAME (Type) Agustin del Campo M.D.  222. PHYSICIAN'S NAME (Type) Agustin del Campo M.D.  223. BURIAL CREMATION. 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, tawn, or county) (State) BURIAL Specify) 6-7-60 St. Paul's Lutheran Myersville, Fred Co Md.  24. FUMERAL DIRECTOR'S SIGNATURE ADDRESS 25d. REGISTRAR'S SIGNATURE	MEDIC	Hour a. m.  p. m.  19 While Not while fact at work at work	tory, street, affice bldg., etc.)
226. DA  226. PHYSICIAN'S NAME (Type Agustin del Campo M.D.  236. BURIAL, CREMATION, 236. DATE THEREOF REMOVAL (Specify) BURIAL  236. REC'D BY REGISTRAR  226. DA  226. DA  226. DA  226. DA  226. DA  226. PHYSICIAN'S DIRECTOR DIR		21. I certify that (I) (this haspital) attended the deceased fram saw the deceased alive an 6-5-19 60, and that deceased	
NAME (Type Agustin del Campo M.D. Springfield State Hospital Sykesville, M.  23a. BURIAL, CREMATION. 23b. DATE THEREOF St. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, tawn, or county) (State)  PUTI 21 6-7-60 St. Paul's Lutheran Myersville, Fred. Co. Md.  24. FUMERAL DIRECTOR'S SIGNATURE ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE		Caustin del Campo A	A.D. ATTENDING MED. STAFF ATTENDING DIRECTOR PHYS. PHYS.
REMOVAL (Specify) 6-7-60 St. Paul's Lutheran Myersville, Fred. Co. Md.  24. FUMERAY DIRECTOR'S SIGNATURE ADDRESS 25G. REC'D BY REGISTRAR'S SIGNATURE  ADDRESS 25G. REC'D BY REGISTRAR'S SIGNATURE		NAME (Typin)	Springfield State Hospital Sykesville, Md.
		REMOVAL (Specify) 6-7-60 St. Paul's	Lutheran Myersville, Fred Co. Md.
	24.	FUNERAL DIRECTOR'S SIGNATURE ADDRESS	

CHOI

R ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 how after death. Page 4 and by the haspital ar attending physician.

TO HOSPIT VR A15 (4) 15M 9/59

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CERTIFICATE OF DEA	ATH

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5795	CERTIFICA	TE OF DEATH		00001
1. PLACE OF DEATH o. COUNTY Carroll	MARYLAND	2. USUAL RESIDENCE (WHO STATE Maryland	nere deceased lived. If institution b. COUNTY	n: Residence before admission)  Garrett
b. CITY OR TOWN (If outside corporate limits, a RURAL and give nearest town)	write c. LENGTH OF STAY IN 16	c. CITY OR TOWN (If o	outside corporate limits, write RU	RAL and give nearest town)
Sykesville	8 days	Kitzm	iller	11X-2
d. NAME OF HOSPITAL (If not in hospital, give OR INSTITUTION		d. STREET ADDRESS		e. IS RESIDENCE
Springfield State	e Hospital			ON A FARM? YES NO
3. NAME OF First DECEASED	Middle	Last	4. DATE Month	n Day Yeor
(Type or print) Walt	ter C.	Iman	DEATH June	6 1960
5. SEX   6. COLOR OR RACE   7.	MARRIED NEVER MARRIED	8. DATE OF BIRTH		IF UNDER 1 YEAR IF UNDER 24 HRS
Male White w	IDOWED DIVORCED	October 8, 1	892 lost birthdoy) 67 yrs.	Months Doys Hours Min.
00. USUAL OCCUPATION (Give kind of work done	e 10b. KIND OF BUSINESS OR INDU			12. CITIZEN OF WHAT COUNTRY
during most of working life, even if retired)	CONT MINES	West Vi	rginia	U.S.A.
3. FATHER'S NAME	T COPT MINES	14. MOTHER'S MAIDEN N	NAME	
SION T ** ** ** ** ** ** ** ** ** ** ** ** *	-	11 who		
5. WAS DECEASED EVER IN U. S. ARMED FORCES	7 16. SOCIAL SECURITY NO. 17. II	NFORMANT	Addre	ess
(Yes, no, of unknown) (If yes, give war or dates of service	113 ***** Sp	ringfield Hos	pital Records.	Sykesville, Md.
18. CAUSE OF DEATH [Enter only one couse	10.00			INTERVAL BETWEEN
PART I. DEATH WAS CAUSED BY:	Acute coronary	inauffiaiana		ONSET AND DEATH
IMMEDIATE CAUSE (o)	Acute coronary	Tusuillelend		yearo
Conditions if now which	tubout and amph	is boomt disc		vears
gove rise to immediate	Arteriosclerot	TG Weste GISe	839	yours
couse (o), stoting the under-	Generalized ar	teriosclerosi	g	vears
/ (0)			*	N IN PART 1(A) 19 WAS AUTOPSY
¥			INAL DISEASE CONDITION ON	PERFORMED?
Acute Brain Syndr	ome of unknown ca		Port I or Port II of item 18 )	152   140
OR CONTRIBUTING CONTRIBUTING (IF EITHER, NOTIFY MEDICAL EXAMINER)	D. DESCRIBE HOW INJURY OCCURRE	D. (Enter noture of injury in	ron i or ron ii or nem iu.)	
-	20d. INJURY OCCURRED 20e. PL	ACE OF INJURY (Home, farm	, 20f. (City or town)	(County) (State
ш 10	While Not while fo	ctory, street, office bldg., etc	.)	
		Morr 28	60 to June 6	60
21 I certify that (1) (this hospital) o	attended the deceased fram			, 19 <u>60</u> , that (1) (we) los
saw the deceased olive anjune	1900, ond that c	death occurred at	M, If ball the couses and	-
220. SIGNATURE	Cel Campo	M.D. ATTENDING M	ED. STAFF PHYS.	June 6, 198
PZC PHYSICIAN'S NAME (Type)		22d. ADDRESS		
/ Agustin del	Campo, M.D.	Springfiel	d Hospital, Syl	kesville, Md.

23c. NAME OF CEMETERY OR-CREMATORY

ADDRESS

23d. LOCATION (City, town, or county)

250. REC'D BY REGISTRAR

DATE JUN 1 0 '60

25b. REGISTRAR'S SIGNATURE

arilung 8. Kraus

(Stote)

may be recorded by the haspital ar attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the ottending physician and campletely filled page 3 shauld be detached for use as the burial-transit permit. Then please remave carbon papers. Pages 1 of the State Board at Health priar to burial, cremation, or remavol, and in any event, within 72 hours after death.

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24

fter death. Page 4

funeral director,

TO HOSPIT VR A15 (4) 15M 9/59

BURIAL, CREMATION, REMOVAL (Specify)

24. FONERAL DIRECTOR'S STONATURE

23b. DATE THEREO!

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERT	TIFICA	TE OF	DE	ATH

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	OFIGE					1111111	
1. PLACE OF DEATH o. COUNTY	0730 Carroll	MARYLAND	2. USUAL RESIDENCE (Who o. STATE Maryl	- h	COUNTY	sidence before od Baltimore	
RURAL ond give n		c. LENGTH OF STAY IN 16	c. CITY OR TOWN (IF o	outside corporate lim	its, write RURAL	ond give nearest	lown)
OR INSTITUTION	TAL (If not in hospital, give street	oddress)	d. STREET ADDRESS			0	RESIDENCE N A FARM?
Spri	ngfield State H	lospital	5 N. Exe	ter Stree	t	YES	□ NO X
3. NAME OF DECEASED (Type or print)	First  Lambert	Middle W.	Johnson	4. DATE OF DEATH	June	28	Yeor 19 60
s. sex	6. COLOR OR RACE 7. MAR WIDOW		8. DATE OF BIRTH Unknown	lost	(In years IFUN birthdoy) Moni	ths Doys Ho	7
100. USUAL OCCUPATION	ON (Give kind of work done 10b. rking life, even if retired)		USTRY 11. BIRTHPLACE (Stote	or foreign country) Unkn	12	CITIZEN OF WH.	J.S.A.
	Unknown				Unkno	wn.	
15. WAS DECEASED EVI	ER IN U. S. ARMED FORCES? 16 (If yes, give wor or dates of service)	SOCIAL SECURITY NO. 17.	INFORMANT ringfield Hosp	ital Reco	rds, Syk	cesvil <b>k</b> e,	Md.
Conditions, if a gove rise to couse (o), stating lying couse lost.	the under-	Laennec's Ci		6			rs
$\leq$	HER SIGNIFICANT CONDITIONS		JT NOT RELATED TO THE TERM	INAL DISEASE CONI	DITION GIVEN IN	PE	REORMED?
20g. ACCIDENT W OR CONTRIBUTING (IF EITHER, NOTIF)			RED. (Enter noture of injury in	Port 1 or Port 11 of i	tem 18.)		
Hour o.m.	19 While of wo	e Not while ork ot work	PLACE OF INJURY (Home, form factory, street, office bldg., etc	:.)		(County)	(Stote)
saw the decea	at (I) (this haspital) attenused alive an June 2	ded the deceased fram 8, 1960, and that		60, to June	auses and an	19, that ( the date sta	ted abave.
220. SENATURE	s f. ma	19 Kin		ED. STA	FF. 🛣	June 29	, 1986 , 1986
22c. PHYSICIAN'S NAME (Type)	Ellis S. Margo	lin	22d. ADDRESS Springfield	d Hospita	L, Sykes	ville, M	d.
230. BURIAL, CREMATIC REMOVAL (Specify	ON, 23b. DATE THEREOF	7 LUC PA	OR CREMETORY /	23d. LOCATION (	Minace	- , My	(Stote)
24. FUNERAL DIRECTOR	R'S SIGNATURE	ADDRESS (	DATE JU	D BY REGISTRAR	25b. REGISTRAR	S. Kraus	

VR A15 (4) 15M 9/59

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25g, REC'D BY REGISTRAR

MARYLAND

IF UNDER 1 YEAR IF UNDER 24 HRS.

12. CITIZEN OF WHAT COUNTRY?

INTERVAL BETWEEN ONSET AND DEATH

vears

vears

(County)

PERFORMED?

YES NO TO

(Stote)

(Stote)

U.S.A.

Months Doys

e. IS RESIDENCE

ON A FARM?

YES NO

1960

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

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1 5	RAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by the funeral director,	should be detached far use as the burial-transit permit. Then please remayer achon papers. Pages 1 and 2 should be filled with	te Board of Health prior to burial, cremation, ar remaval, and in any event, within Ng haurs ofter death.	
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death

ATTENDING PHYSICIAN: The law requires that the

VR A15 (4)

15M 9/59

PLACE OF DEATH

Carrol!

a. COUNTY

b. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest lown) XB6XXXXXXXX Towson 4 Sykesville d. NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS OR INSTITUTION Springfield State Hospital 8521 Willow Oak Road NAME OF 4. DATE Middle Month DECEASED Kaufer DEATH June (Type or print) Rose Mary 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 5. SEX B. DATE OF BIRTH 9. AGE (In years lost birthdoy) February 19, 1876 Female White WIDOWED A DIVORCED | 84 yrs. 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Stote or foreign country) during most of working life, even if retired) Housewife Pennsylvania 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Catherine Scheidt 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO 17 INFORMANT Springfield Hospital Records, Sykesville, Md. NO 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] PART I. DEATH WAS CAUSED BY: Arteriosclerotic cardiovascular disease IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which Generalized arteriosclerosis gove rise to immediate DUE TO couse (a), stating the underlying couse lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY CBS associated with cerebral arteriosclerosis, with psychotic reaction. 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20c. TIME OF INJURY 20e. PLACE OF INJURY (Home, form, 20f. (City or town) 20d. INJURY OCCURRED foctory, street, office bldg., etc.) While Not while of work of work 1960 to June 6, 21. I certify that (I) (this hospital) attended the deceased from May 16 19 60, and that death occurred of 0:45, from the couses and on the dote stated above saw the deceosed olive on June 6. 220 SIGNATURE M.D. PHYS. STAFF PHYS. MED. DIRECTOR 22c PHYSICIAN'S 22d, ADDRESS NAME (Type) Agustin del Campo Springfield Hospital, Sykesville, Md. may be page 3 the Stat 230 BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town, or county) Towson 4. Md. Burial Prospect Hill EO

Brooks Funeral Service, Towson4, Md.

4 money resolved AT AUST ALL PRINCES IN LIBRARY DAY . . the base of the second of the the self is a state of the self in the sel Committee and Co A STATE OF S .Ed . 4 gosspin \_\_\_\_\_fil deepsort \_\_\_\_\_ co-e-d falted Strooms Lament Service, lowered, Md.

Reg. Dist. No.

e. IS RESIDENCE

Hours

12. CITIZEN OF WHAT COUNTRY?

United States

Day

18

Days

YES NO K

Yeor

1960

06764

Jacob Thomson	Mary Robison
15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INI	ORMANT Address
Mns	J. T. Knode, Woodstock, Va.
18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), ond (c).]  PART I. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (o)	Lescular Reyal Several
Conditions, if ony, which gave rise to immediate couse (o), stoting the under-lying couse lost.	athour Volumbar
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT N	OT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES NO
OR CONTRIBUTING CAUSE OF DEATH OF EITHER, NOTIFY MEDICAL EXAMINER)	(Enter nature of injury in Port I or Port II of item 1B.)
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED Hour o. m.  P. m. 19 While Not while at work of twork 19 of work 19 of work 19 of work 19	E OF INJURY (Home, farm, 20f. (City or town) (County) (Slote) ry, street, office bldg., etc.)
21. I certify that I attended the deceased from afficient alive an 1960, and that death of the control of the c	accurred at 7.30 PM, from the causes and an the date stated above.  ADDIESS (Street, city or tofin, state)  DATE SIGNED
PHYSICIAN'S NAME (Type)	Massimules ma Glago
220. BURIAL, CREMATION, REMOVAL (Specify) Burial June 21,1960 Westminster	
23. FUNERAL DIRECTOR'S SIGNATURE APORESS T. E. Myers Westminster;	Md. DATELLIN 2 2 160 Culling S. Knows

TO FUNERAL VS A1S (4) 15M 9/SS

the registrar

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### MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

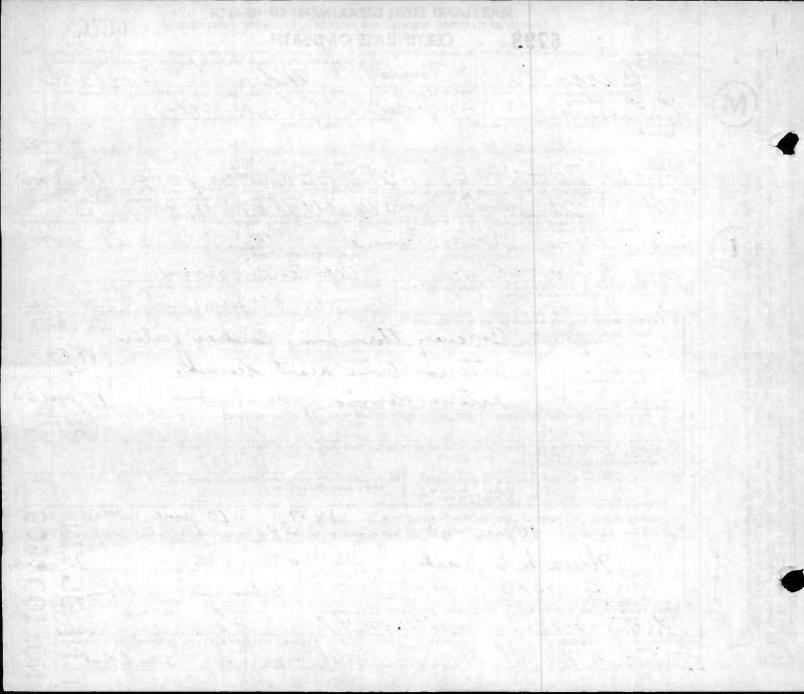
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0100 CERTIFICA	AIL OF DEATH
1. PLACE OF DEATH O. COUNTY CARROLL MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE b. COUNTY
b. CITY OR TOWN (If gutside corporate limits, write RURAL and give negrest town)	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS  e. IS RESIDENCE ON A FARM? YES \( \) NO
NAME OF DECEASED (Type or print) Dr. Jo HM B, Middle	ERNER 4. DATE June 10 1960
6. COLOR OR RACE 7. MARRIED NEVER MARRIED WIDOWED DIVORCED	B. DATE OF BIRTH  OLIVITY 1889  9. AGE (In years left UNDER 1 YEAR IF UNDER 24 HR: lost birthday)  7 yrs. Months Days Hours Min.
Oa. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  The ware and the control of working life, even if retired)	1 ml 4, CA
John B. Holerner, Se	Migusta Bligman
5 WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. (If yes, give wor or dates of service)	Mo Marie E. Holener. Address me
Conditions, if ony, which gove rise to immediate couse (a), stoting the under-lying couse lost.  (b) Carlerus Clar  (b) Laterus Clar  (c) Laterus Clar	when heart desease, to
lying couse lost. (c) with the course clus	ut not related to the terminal disease condition given in part 1(0) 19. Was autops
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BE	PERFORMED? YES NO
OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	RED. (Enter nature of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED While Not while of work of work of the other p.m.	PLACE OF INJURY (Home, form, 20f. (City or town) (County) (Stot foctory, street, office bldg., etc.)
21. I certify that (I) (this hospital) oftended the deceosed from sow the deceased alive on 10 mal 1960 and that	n. 1959 19 to 10 pure, 1960, that (1) (we) la
220. SIGNATURE Howard & Hall	M.D. ATTENDING MED. STAFF PHYS. STAFF
22c. PHYSICIAN'S NAME (Type) HOWARD E. HALL	22d. ADDRESS Achearlle 1 Med
133. BURIAL CREMATION, 236. DATE THEREOF REMOVAL (Specify) 6-13-60 23c. NAME OF CEMETERY	OR CREMATORY 23d. LOCATION (City, town, or county) (State)
AUTHOR A PHILIPPE ADDRESS ADDRESS	250. REC'D BY REGISTRAR 256. REGISTRAR'S SIGNATURE  DATE HIN 1 6 '60 Cuthing S. Kraus

fter death. Page 4 may be rehaved by the haspital ar attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by the funeral director, page 3 shauld be detached far use as the burial-transit permit. Then please remave carbon papers. Pages 1 and 2 shauld be filed with the State Board of Health priar to burial, cremation, or remaval, and in any event, within 72 hays after death. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 ha R ATTENDING PRINCIPLY. TO HOSPITA

VR A15 (4) 1SM 9/S9



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TO HOSPIT R ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours offer death. Page 4	may be retained by the hospital or ottending physicion.  TO FUNERAL DIRECTOR: After this certificate has been signed by the ottending physician and completely filled in by the funeral director,	page 3 should be detached for use as the burial-transit permit. Then please remove corbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours offer death.	
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VR A15 (4) 15M 9/59

UMAT	02111111111			
1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Whe	re deceased lived. If institution b. COUNTY	: Residence before admission)
Carroll	MARYLAND	Maryl		Balto, City
<ul> <li>CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</li> </ul>	c. LENGTH OF STAY IN 16		tside corporate limits, write RUR	(AL and give nearest town)
Sykesville	7yrs.6mos.4day	rs Baltim	ore 29	VUI-4-
d. NAME OF HOSPITAL (If not in hospital, give street or INSTITUTION		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM?
Springfield State Hospita	al	111 A1	lendale St.	YES NO
3. NAME OF First DECEASED (Type or print) Doris	Marie	Markland	4. DATE Month OF DEATH June	30, Yeor
5. SEX Female  6. COLOR OR RACE White Widows		Sept. 3, 192	last histhday)	FUNDER 1 YEAR IF UNDER 24 HR: Months Doys Hours Min.
10a. USUAL OCCUPATION (Give kind of work done 10b. during most of working life, even if retired)	KIND OF BUSINESS OR INDUS	TRY 11. BIRTHPLACE (Stote of Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.
13. FATHER'S NAME  Lawrence Markland		Ruth Hard		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (It yes, give wor or dates of service)		pormant opringfield Ho	Addres Spital Records	
1B. CAUSE OF DEATH (Enter only one couse per line PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (c)  DUE TO	ne for (o), (b), ond (c).] ar advanced pul	monary tubero	ulosis	INTERVAL BETWEEN ONSET AND DEATH Lears
Conditions, if ony, which gove rise to immediate couse (a), stating the under-lying couse lost. (b)				
PART II. OTHER SIGNIFICANT CONDITIONS C Schizophrenic reaction,  200. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				N IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO
	CRIBE HOW INJURY OCCURRED	). (Enter noture of injury in P	ort I or Port II of item 18.}	
Hour o. m. While		CE OF INJURY (Home, form, tory, street, office bldg., etc.)		(County) (State
21. I certify that (I) (this haspital) attends saw the deceased alive an June 30				
220. SIGNATURE This I	2 at 1	ATTENDING ME	PARAMETER IN	22b. DATE SIGNE 6/30/6
22c. PHYSICIAN'S NAME (Type) Ellis S. Margo	lin, M.D.	22d. ADDRESS		
230. BURIAL DREMATION, 23b. DATE THEREOF, REMOVAL (Specify)	230 NAME OF CEMETERY OF	CREMATORY ST LEM	234 tocation isity, town, or DALTO	county) (Stote)
24 FUNERAL DIRECTOR'S SIGNATURE	ADDRESS 1 22	250. REC'D		RAR'S SIGNATURE

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

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	O FUNERAL DIRECTOR: After this certificate has been signed by the attending physician pad campletely filled in by the funeral directar,	page 3 shauld be detached far use as the burial-transit permit. Then please remave of backs. Pages 1 and 2 shauld be filed with	B
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may be red by me mashing or anemally significant	IIQ 7	plug	the State Board of Health prior to burial, cremation, or removal, and in any event within 79-bour offer death.
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R ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 ha

VR A1S (4) 1SM 9/59

1. PLACE OF DEATH o. COUNTY ALL	oll	MARYLAND	2. USUAL RESIDENCE (W		institution: Residence	e before admission)
b. CITY OR TOWN (If outside BURAL and give nearest to	Misville 10	O YEARS	C. CITY OR TOWN (IF	Outside corporate limits,	11/2	ive nearest town)
OR INSTITUTION	at in haspital, give street address		d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES NO
3. NAME OF DECEASED (Type or print) BO	YD OUMM	Middle /	IETCALF.	4. DATE OF DEATH	Manth	9 1960
m	WIDOWED [	DIVORCED	S. DATE OF BIRTH	7.5 Rost bir	thday) Months yrs.	1 YEAR IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Giver a during most of working life and the state of the sta		Cotton Ma	TA. MOTHER'S MAIDEN	nd	12. CITIZ	S. A.
15 WAS DECEASED EVER IN U. (Yes. no. or unknown) (If yes, gi	S. ARMED FORCES? 16. SOCIAL ve war or dates of service)		Catherine NFORMANT	11 mite	Address	from the Sul
18 CAUSE OF DEATH (F	nter only one couse per line for (		nn p.mae	cc//perent	z-cayn	INTERVAL BETWEEN
			TWE CADITIONA	SCULAR DISEA	CTP .	ONSET AND DEATH
Conditions, if only, wh gave rise to immedi couse (o), stoting the un	ich (b) WITH AF	RTERIOSCLER	OSIS AND MYOC		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	20 yrs.
lying cause last.	(c) Chronic	glomerulo	nephritis			same
¥	ANCED SENILE CH				ION GIVEN IN PART	1(a) 19. WAS AUTOPSY PERFORMED? YES NO X
200. ACCIDENT WAS UND OR CONTRIBUTING CA (IF EITHER, NOTIFY MEDIC	ERLYING 20b. DESCRIBE HUSE OF DEATH AL EXAMINER)	HOW INJURY OCCURRE	D. (Enter noture of injury in	Port I or Port II of item	18.)	
20c. TIME OF INJURY Mai Haur o. m. p. m.		Nat while fo	ACE OF INJURY (Hame, for ctory, street, office bldg., e	rm, 20f. (City or town)	(C	ounty) (State)
sow the deceosed al	this hospital) oftended th					
22a. SIGNATURE	Sourant.		M.D. PHYS.	MED. STAFF PHYS.		22b. DATE SIGNED 6/9/60
NAME (Type) Wm.	H. Lawson, Jr.	, M.D.	22d. ADDRESS Sykesv	ille P.O.,	Maryland	
230 BURIAL, CREMATION, 231 REMOVAL (Specify)	DATE THEREOF 23c.	HAME OF GEMETERY OF	Methodist	23d. LOCATION (City	E Bello.	Eo. md.
24. FUNERAL DIRECTOR'S SIGN	Haight !	Hypersill	25a. REI	C'D BY REGISTRAR 25	Sb. REGISTRAR'S SIG	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

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1. PLACE OF DEATH G. COUNT Carroll	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY Adams						
b. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) Rural, Sykesville	c. LENGTH OF STAY IN 16  4 Weeks	c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town)  Littlestown						
d. NAME OF HOSPITAL (If not in hospital, give street OR INSTITUTION  Golden Age Guest Home, Syke		d. STREET ADDRESS  N. Queen Street  on A FARM? YES \( \) NO [						
3. NAME OF First DECEASED (Type or print) Simon	Miller 4. DATE Manth Day Year OF DEATH 6/10/60 19							
Male White WIDOWE	DIVORCED [	B. DATE OF BIRTH 7/30/1880  9. AGE (In years last birthday) 79 yrs.    IF UNDER 1 YEAR   IF UNDER 24 HR   Manths   Days   Hours   Min.						
	KIND OF BUSINESS OR INDUS	ISTRY 11. BIRTHPLACE (State or foreign country)  Adams Co., Pa.  12. CITIZEN OF WHAT COUNTRY  U.S.A.						
Simon Miller		14. MOTHER'S MAIDEN NAME Ella Sheely						
(Yes, no. or unknown) . (If was give wor or dates of service)		Address 349 Lumber Stelvin A. Miller, Littlestown, Pa.						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  Canditians, if any, which gove rise ta immediate cause (a), stating the under- lying couse last.  PART II. OTHER SIGNIFICANT CONDITIONS C	CONTRIBUTING TO DEATH BUT	T NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPS PERFORMED? YES \( \cappa \) NO \( \cappa \)						
GR CONTRIBUTING CAUSE OF DEATH	CRIBE HOW INJURY OCCURRED	D. (Enter nature of injury in Part I ar Part II of item 18.)						
20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED While at wark   20e. PLACE OF INJURY (Hame, farm, 20f. (City ar tawn))  21. I certify that (I) (this haspital) attended the deceased fram.  21. I certify that (I) (this haspital) attended the deceased fram.  22. Start fure  22. PHYSIC FAN'S  MAME (Type)  ATTENDING  MED.  STAFF  DIRECTOR   PHYS.    22. PHYSIC FAN'S  MAME (Type)  22. PHYSIC FAN'S  MAME (Type)  ATTENDING  MED.  STAFF  DIRECTOR   PHYS.    22. PHYSIC FAN'S  MAME (Type)  PHYS.   22. PHYSIC FAN'S  MAME (Type)  PHYS.   22. PHYSIC FAN'S  MAME (Type)  PHYS.   22. PHYSIC FAN'S  MAME (Type)  PHYS.   22. PHYSIC FAN'S  MAME (Type)  PHYS.   22. PHYSIC FAN'S  MAME (Type)  PHYS.   22. PHYSIC FAN'S  MAME (Type)  PHYS.   22. PHYSIC FAN'S  PHYS								
24. EUNERAL DIRECTOR'S SIGNATURE.  LEGICAL A TITLE  L	ittlestown, Pa	250. REC'D BY REGISTRAR 256. REGISTRAR'S SIGNATURE  DATE JUN 1 3 '60 Cuthing S. Hims						

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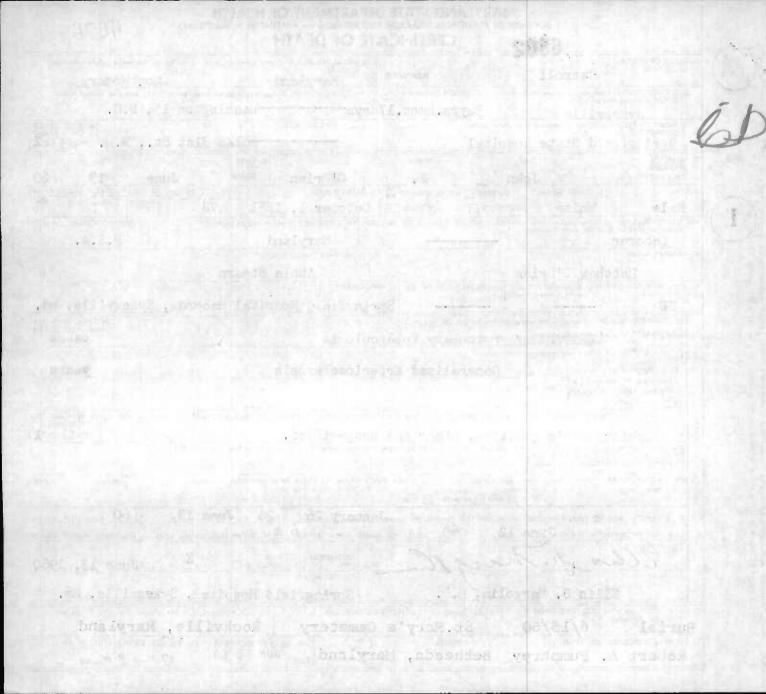
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after death. Page 4

40SPIT. BR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 har after death. Page 4 UNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by the funeral director, ge 3 shauld be detached far use as the burial-transit permit. Then please remove carban papers. Pages 1 and 2 should be filed with 5 state Board af Health priar to burial, crematian, ar remaval, and in any event, within 72 hydrs after death.

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VR 1S	M	9/5	9	. 7

		681	19	CER	RTIFICA	TE OF DEA	TH			(, (	600	,
1. PLAC a. CC	CE OF DEATH DUNTY	Carroll			MARYLAND	2. USUAL RESIDENCE O. STATE		sed lived. If insti b. COUN	ITY.	esidence bef		sion)
b. CI	TY OR TOWN (If JRAL and give nee	autside corporate lim	its, write	c. LENGTH OF	STAY IN 16	c. CITY OR TOWN		porate limits, writ				n)
RC		ville		34yrs.1	mos.17	days	Was	shington	15,	D.C.	4	7X-3
d. N		L (If not in hospital,	give street			d. STREET ADDRE	ESS				e. IS RES	FARM2
		eld State	Hospi	tal			6	L48 31st	St.	, N.W.	YES [	
3. NAM	NE OF	Fi	rst	1	Middle	Last	4. DATE	E A	Aonth	D	ау	Year
	EASED e ar print)	John			F.	O'Brien		of DEATH June			13 1960	
5. SEX		6. COLOR OR RACE		IED NEVER /	- ANDRE	B. DATE OF BIRTH		O AGE (In yes	IF LI	NDER I YEA	-	
Ma	le	White	WIDOWE	DIV	VORCED [	October 1.	. 1881	lost birthdo	y) Mo	nths Days	Hours	Min.
10a. USI	UAL OCCUPATIO	N (Give kind of work	done 10b.	KIND OF BUSIN	NESS OR INDI	JSTRY 11. BIRTHPLACE				2. CITIZEN O	FWHAT	OUNTRY?
dur	Laborer	ng life, even if relired	1)			Mary:	land			U.S	.A.	
13. FATH	HER'S NAME					14. MOTHER'S MAI						
	Matt	hew O'Bri	an			Anı	nie Stea	arn				
	DECEASED EVER	IN U. S. ARMED FO	RCES? 16.	SOCIAL SECURIT	TY NO. 17.	NFORMANT			Address			
	or unknown) (1	f yes, give war or dates of	service)		St	ringfield H	Hospital	Records	3. S	vkesvi	lle.	Md.
		TH [Enter anly ane a	ouse per lin	ne far (a), (b), or					7	IN	ERVAL BE	TWEEN
	PART I. DEAT	H WAS CAUSED BY:	, P	n] monary	Tuber	culosis				ON	VEA.	
1	7021	DUE TO			, - 0.00-	00200					<i>y</i>	
C	onditions, if an	which )	C	eneralia	zed Art	erioscleros	eis				vea	rs
go	ove rise to im	mediote (	-	OHOLGIL	DOG RI	,0110001010.	020		777		200	
	use (a), stating t	he under-								3946		
NO	PART II. OTHI	ER SIGNIFICANT CON	NDITIONS C	ONTRIBUTING	TO DEATH BU	T NOT RELATED TO THE	TERMINAL DISE	ASE CONDITION	GIVEN II	N PART 1(o)	19. WAS	AUTOPSY
ATIC	Cohine	nhrania r	anati	on other	hre re	unspecifie	3				YES T	NOT
E 20a	. ACCIDENT WAS	UNDERLYING I				ED. (Enter nature of inju		Part II af item 1B.)				
oc OR	CONTRIBUTING	CAUSE OF DEATH										
₹ 20c.	TIME OF INJURY	Month, Doy, Ye	ar 20d. It	NJURY OCCURRE	ED 20e. P	LACE OF INJURY (Hame	, farm, 20f. (C	ity or tawn)		(County	)	(Stote)
MEDI	Hour a.m.	19	While of world	Not while		actary, street, office bldg	g., etc.)					
-	-	mm 2-3 1 1 1.		h-a-d 1		Innuary 26	26	June 13		60		
	SIGNATURE	ed alive anJun	0_1k_	1900,	and that	death accurred at	M, fra	m the causes	and a	n the date	e stated	abave.
	Elle	o di	ma	ng M	1	M.D. ATTENDING PHYS.	MED. DIRECTOR	STAFF THYS.		June	13.	SIGNED
220	PHYSICIAN'S NAME (Type)			1		22d. ADDRESS						
	E.	llis S. Ma	rgoli	n, M.D.		Springf	ield Ho	spital,	Syke	sville	, Md	
	RIAL, CREMATION				F CEMETERY	OR CREMATORY		CATION (City, taw			(Stot	
_ REA	MOVAL (Specify)	6/15/6	0	1 200		Cemetery		ckville				
	ERAL DIRECTOR'S	SIGNATURE	-51	ADDRESS		250	REC'D BY REG	ISTRAR 2Sb. RI	*	R'S SIGNATU		
Ro	obert A	. Pumphr	<b>F</b> y	Bethes	da, M	aryland DAT	TE JUN 1	60	7.11	" 8. H	alla	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
ROPE
CERTIFICATE OF DEATH

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1. PLACE OF DEATH 0. COUNTY			MARYL		usual RESIDENCE (Who of STATE Maryland	ere deceased live	b. COUNTY BE	Residence befaltimor	ore admission) e City	
	N (If outside corporate limits	s, write c.	LENGTH OF STAY IN	V 16	c. CITY OR TOWN (If o		imits, write RURA	AL and give no	earest lown)	
RURAL ond giv	kesville	5	mos. 20	davs	Baltimo	re		3 V	nich	
d. NAME OF HO	SPITAL (If not in haspital, gi				d. STREET ADDRESS				e. IS RESIDENCE	
OR INSTITUTIO	Springfield	State	Hospital		1703 Sher	wood Ave	nue		YES NO K	
3. NAME OF	First		Middle		Lost	4. DATE	Month		Day Year	
DECEASED (Type or print)		garet	Elizab	eth	Peacock	OF DEATH	June	2]	1960	
5. SEX	6. COLOR OR RACE	7. MARRIED	NEVER MARRIED	B. C	DATE OF BIRTH	9. A		UNDER 1 YEA	R IF UNDER 24 HRS. Hours Min.	
Female	White	WIDOWED [	DIVORCED	□ Au	gust 26, 18	85	74 yrs.	Days	Hours Min.	
10a. USUAL OCCUP.	ATION (Give kind of work di working life, even if retired)	one 10b. KIN	ID OF BUSINESS OR	INDUSTRY	11. BIRTHPLACE (State	or foreign country	'}	12. CITIZEN C	F WHAT COUNTRY?	
	sewife	-			Maryla	nd		U.S.	.A.	
13. FATHER'S NAME				1	4. MOTHER'S MAIDEN N			114.41	1000	
	James M. Bo	ston				Susie	E. Coll:	ins		
IS. WAS DECEASED	EVER IN U. S. ARMED FORCE	ES? 16. SOC	CIAL SECURITY NO.	17. INFO	RMANT		Address			
(Yes, no. or unknown) NO	(If yes, give war or dates of see	rvice)	NONE	Spri	ngfield Hos	pital Re	cords,	Sykesvi	llle, Md.	
	DEATH [Enter only one cau	use per line fo	or (a), (b), and (c).]						TERVAL BETWEEN	
PART I.	DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Br	oncho	pneumonia				weeks	
115	DUE TO									
Conditions,	if ony, which ) (b).		Ge	neral	ized arteri	oscleros	is		years	
	o immediate									
lying couse le										
Z PART II.	OTHER SIGNIFICANT CONE		ITRIBUTING TO DEAT	TH BUT NO	T RELATED TO THE TERMI	NAL DISEASE CO	NDITION GIVEN	IN PART 1(o)	19. WAS AUTOPSY	
CBC OCO	oc. cerebral	orteri	osclarosi	9. W	th psychot	ic react	ion		PERFORMED?	
20g. ACCIDENT					Enter noture of injury in I					
	TIFY MEDICAL EXAMINER)									
	IJURY Month, Day, Yea				OF INJURY (Home, farm		own)	(County	(Stole)	
Hour o.	m. m.	While of work	Not while at wark	100101	y, areer, office blug., etc.	·/ i				
of Leastifue	that (I) (this haspital)	attended	the deceased f	.cm.Tai	1118rv 1. 10	60 to Jur	e 21.	10 60	that (1) (we) last	
saw the dec	eased alive an June	21,	1960 , and t	hat dea				an the dat	re stated above.	
22a. SIGNATUR	links m	01 10	3 HP	м. с	ATTENDING ME	ED. SI	AFF X	Jun	e 21, 1968	
22c. PHYSICIAN		1	11000	.,,,,,	22d. ADDRESS					
NAME (Typ	Ellis S. Mar	rgolin	, M.D.		Springfiel	ld Hospit	cal, Syk	esvill	e, Md.	
23a BURIAL CREMA REMOVAL (Spe		60 2	32 NAME OF CEMET	ELVES	REMATORY	23d. LOCATION	(City, town, or o	County)	(State)	
24 FUNERAL DIRECT	TOR'S SIGNATURE	1	ADDRESS	/	25a. REC'	D BY REGISTRAR	2Sb. REGISTR	AR'S SIGNAT	ÜRE	
Leonal	X X Rucs	20	500 /t	and	PATEN S	2 2 '60	Called	& Frank		

TO HOSPITA R ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 how therefore death. Page 4 may be retained by the haspital ar attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by the funeral director, page 3 shauld be detached far use as the burial-transit permit. Then please remaye carban papers. Pages 1 and 2 shauld be filed with the State Board of Health prior to burial, cremation, ar remayal, and in any every within 2 haurs after death.

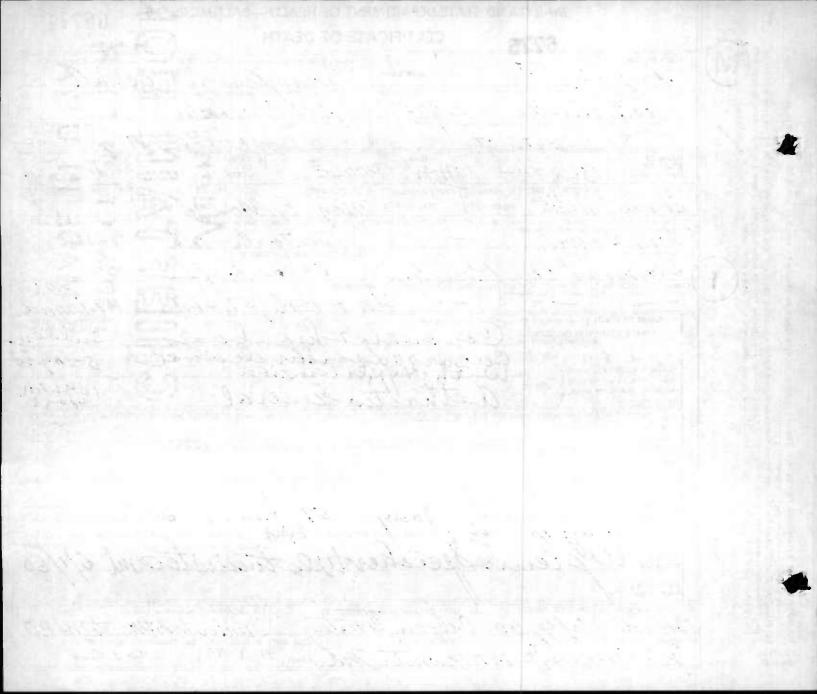
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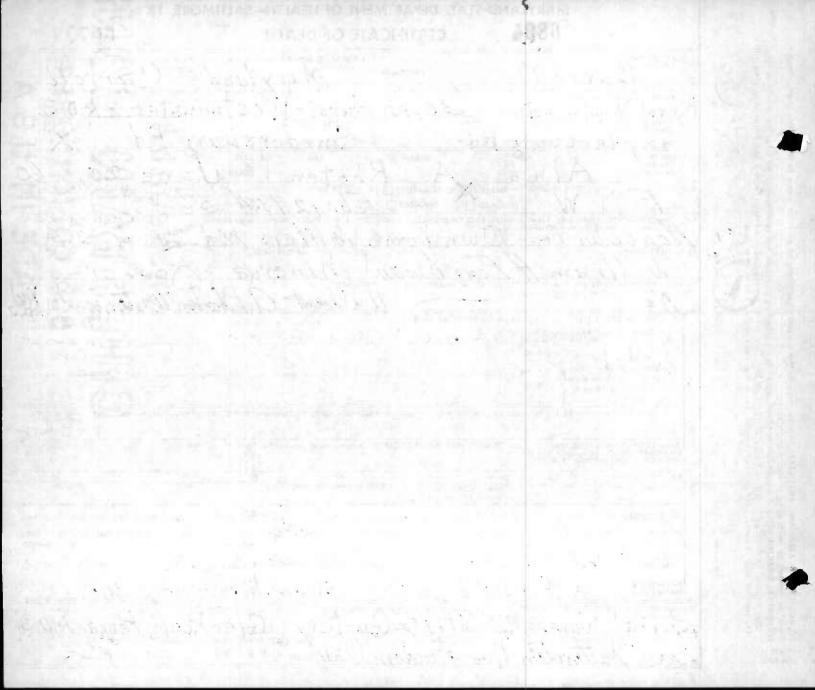
6775	CERTIFICA	ATE OF DEATH		Reg. Dist. No.
1. PLACE OF DEATH o. COUNTY	MARYLAND	2. USUAL RESIDENCE (Who o. STATE	ere deceased lived. If institution b. COUNTY	Residence before admission)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 16	c. CITY OR TOWN UP o	utside corporate limits, write RUI	RAL and give nearest town)
d. NAME OF HOSPITAL (If nat in haspital, give street a OR INSTITUTION	(ddress)	d. STREET ADDRESS	rebeter	e. IS RESIDENCE ON A FARM? YES NO D
3. NAME OF DECEASED (Type or print) BERTHA	MAY F	POOLE	4. DATE Month OF DEATH	- 1'
5. SEX 6. COLOR OR RACE 7. MARRIE WIDOWEE	ED NEVER MARRIED DIVORCED	8. DATE OF BIRTH  Man 10,1	1 1 1 1 1 1 1	FUNDER 1 YEAR IF UNDER 24 HRS. Months Doys Hours Min.
100. USUAL OCCUPATION (Give kind of work done 10b. K during most of working life, even if retired)	(IND OF BUSINESS OR INDU	STRY 11. BIRTHPLACE Stote	or foreign country)	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME	Thelling	14. MOTHER'S MAIDEN N	AME 2411	
5. WAS DECEASEDEVER IN U. S. ARMED FORCES? 16. S (Yes, no, or unknown) (If yes, give war ar dates of service)	SOCIAL SECURITY NO.	es. H. Porti	376xefste	St Westram?
18. CAUSE OF DEATH [Enter only one cause per line PART I. DEATH WAS CAUSED 8Y: IMMEDIATE CAUSE (a)	for (a), (b), and (c).]	N Theor	bosis	INTERVAL BETWEEN ONSET AND DEATH
Conditions, if ony, which ) (b)	udio V K	seglar	Elislase	> 5-104s
gove rise to immediate cause (o), stating the under.  lying cause lost.  DUE TO  (c)	ithrit	is Leve	ral	1041son
PART II. OTHER SIGNIFICANT CONDITIONS CO	DNTRIBUTING TO DEATH BUT	NOT RELATED TO THE TERMI	nal disease condition give	N IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO
	RIBE HOW INJURY OCCURRE	D. (Enter noture of injury in P	ort I or Port II of item 18.)	Y PART I
20c. TIME OF INJURY Manth, Doy, Year 20d. IN. Hour o. m. p. m. 19 While of work	Not while fa	ACE OF INJURY (Home, form, ctory, street, office bldg., etc.	20f. (City or town)	(County) (State)
21. I certify that I attended the decease alive an 2001	)	1957, to 5		nat I last saw the deceased an the date stated abave.
ACTUAL WYLES	Treich		Appress (Street, city or Jown, st	
PHYSICIAN'S NAME (Type)				11/
220. BURIAL, CREMATION, 22b. DATE THEREOF CALL (Specify)	22c. NAME OF CEMETERY O	CREMATORY STATES	22d. LOCATION (City, town, or Member Wys)	county) (Stole)
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS .		1111 0 100	RAR'S SIGNATURE

VS A1S (4) 15M 9/58



death.

	MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18	
	6804. CERTIFICATE OF DEATH	Dist. No. 773
(	1. PLACE OF DEATH a. COUNTY b. COUNTY b. COUNTY b. COUNTY b. COUNTY	grroll
R	b. CITY OR TOWN (If autside carporate limits, write RURAL on give nearest lown)  RURAL ond give nearest lown)  C. LENGTH OF STAY IN 1b  C. CITY OR TOWN (If autside carporate limits, write RURAL on RURAL on the state of the sta	e. IS RESIDENCE
	Snydersburg Rd Snydersburg Rd	YES NO
	3. NAME OF DECEASED (Type or print) A ma A Rhoten. 4. DATE OF DEATH June	20, 1960
	S. SEX  6. COLOR OR RACE  7. MARRIED NEVER MARRIED   8. DATE OF BIRTH  WIDOWED   DIVORCED   6. DY, 12 1904  WIDOWED   DIVORCED   7. MARRIED NOTE   1904  Month	
1	Housewite Own home Millers Md. R.D.	4. S.A.
	13. FATHER'S NAME / I am H. Fourhman, Minerva Ros	ien-
	15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. INFORMANT Wilbert a. Rhoten Wes	tminster M
	18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c),]  PART I. DEATH WAS CAUSED BY:  **MMEDIATE CAUSE (o) Chronic Maje laid Linkernia	INTERVAL BETWEEN ONSET AND DEATH
	Conditions, if ony, which (b)	
7	gove rise to immediate couse (a), stating the <u>under-lying couse last.</u> DUE TO  (c)	
CATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN I	PART 1(0) 19. WAS AUTOPSY PERFORMED? YES NO
CERTIFIC		
MEDICAL	20c. TIME OF INJURY Month, Day, Year Hour o. m.  p. m.  19  20d. INJURY OCCURRED While Not while of work of wo	(County) (State
	21. I certify that I attended the deceased from from the causes and an alive an from the causes and an	last saw the deceased
	ACTUAL SIGNATURE W/8 7 oard M.D. Manchester Md	6-20-60
	PHYSICIAN'S NAME (Type) WHFOARD MArchester	Md
2	220 BYRIAL, CREMATION, 22b, DATE THEREOF 220 NAME OF CEMETERY OF CREMATORY 22d, LOCATION (City, town, or count of the coun	enna R.D.
1	Josepharterden, Hew Forcedown, Jav, DATE JUN 22'60 arthur	S. Krana



IAKILAND	SIAIE	DEPAKIME	NI OF HE	ALIH
OF STATISTICAL	RESEARCH	AND RECORDS	- BALTIMORE	1, MARYLAND

	OF STATISTICAL					
000	CFI	RTIFIC	ATE O	F DE	HTA	

		6805	T+	CERTIFIC	ATE	OF DEATH	MORE I,	MARTLAND		06	77	4
1.	PLACE OF DEATH	arroll		MARYLAN		usual residence (Who		d lived. If instituti b. COUNTY	an: Residence	before	odmiss	sion)
		If autside carporate limi	its, write	c. LENGTH OF STAY IN 1	b	a. STATE  Maryland b. COUNTY Baltimore City  c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						
	RURAL and give n	kesville		5 Mos. 18Day	78	Balti	more		3	VO	1.4	
		TAL (If not in hospital, g	give street		-	d. STREET ADDRESS				e.		SIDENCE FARM?
		ringfield	State	Hospital	1	12 Ilcheste	r Ave	nue				NO X
3.	NAME OF DECEASED	Fir	rst	Middle		Last	4. DATE	Mor	ith	Day		Year
	(Type or print) Annie		nie	Elizabet		Robertson	OF DEATH	Ju	10	22	23	19 60
5.	SEX	6. COLOR OR RACE	7. MARR	RIED NEVER MARRIED	8. 0	DATE OF BIRTH		9. AGE (In years last birthdoy)	Manths De			T -
	Female	White	WIDOWI	ED DIVORCED	1 :	January 6, 1	907	53 yrs.	Months De	ays	Hours	Min.
10	o. USUAL OCCUPATION	ON (Give kind of work king life, even if retired	done 10b.	KIND OF BUSINESS OR IN	IDUSTRY	11. BIRTHPLACE (State of	or foreign o	country)	12. CITIZE	NOFV	WHATC	OUNTRY
	Housewii	_				Marylan	d		U.	S.A		
18.	FATHER'S NAME				- 1	4. MOTHER'S MAIDEN N	AME					
	C	larence A.	Bower	18			Sarah	Harris				
15. (Ye	WAS DECEASED EVE	R IN U. S. ARMED FOR		SOCIAL SECURITY NO. 1	7. INFO	RMANT		Add	ress			
	NO			S	prin	ngfield Hosp	ital	Records,	Sykesv	111	.0,	Md.
	OLD OUT		ouse per li	ne for (o), (b), and (c).]			2 3					DEATH
	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Bilateral bronchopneumonia								Davs			
	203	DUE TO									0	
									Years			
	gove rise to i											
	lying cause lost.	) (c	:)(									
ON N	PART II. OT	HER SIGNIFICANT CON	IDITIONS C	CONTRIBUTING TO DEATH	BUT NO	OT RELATED TO THE TERMIN	NAL DISEAS	SE CONDITION GIV	EN IN PART 1	(0) 19.	. WAS	AUTOPSY DRMED?
S				ecified cause							YES K	NO
CERTIFICATION	OR CONTRIBUTING	AS UNDERLYING  CAUSE OF DEATH MEDICAL EXAMINER)	20b. DES	CRIBE HOW INJURY OCCU	RRED. (	Enter noture of injury in P	Port I or Po	rt II of item 18.)				
MEDICAL	20c. TIME OF INJUI	RY Manth, Doy, Ye				OF INJURY (Hame, form, street, office bldg., etc.		y ar town)	(Co	unty)		(State
WED	p. m.	19	While of wor		, , ,	,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1					
	21. I certify the	at (I) (this hospital	1) attend	ded the deceased fro	m Ja	anuary & 519	60, to	June 23,	19 60	) the	it (I) (	(we) la
				2, 1960 , and the								
	220 SICHATURE	- 1	)	DI							22	b. DATE
	711	1 X as	na	rather	M.D	ATTENDING ME	D. RECTOR	STAFF PHYS.	June	23	, 19	SIGNE
	22c. PHYSICIAN'S NAME (Type)			./		22d. ADDRESS	TT	44-7 0-3	lee ev-177			
		Ellis S. Ma	rgol	in, M.D.		Springfield	Hosp	oitai, Sy	KezAJTI	е,	rkt.	
23	a. BURIAL, CREMATIC			23c. NAME OF CEMETER			23d. LOCA	TION (City, tawn,	or county)	-	(Stol	te)
B	urial (Specify	6-25-19	160	Brandenbu	rg	Cemetery	Cal	rroll Co	, M	ar.	ATS	IId

may be reharded by the haspital ar attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral dispage 3 shauld be detached for use as the burial-transit permit. Then please remove corbon papers. Pages 1 and 2 shauld be file the State Board of Health priar to burial, cremation, ar remayal, and in any event, within 72 hours after death.

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24

TO HOSPITA VR A15 (4) 15M 9/59

24. FUNERAL DIRECTOR'S SIGNATURE

C.M. Waltz,

ADDRESS Winfield , Maryland 25a. REC'D BY REGISTRAR JUN 27'60 DATE

25b. REGISTRAR'S SIGNATURE arthur S. Kenne

after all places of the state o The second facilities in the second or different and hapting a firm of the protection of the contract of the contr The state of the s The state of the s the of the set of the union obeth standards of the first beauty Burgers Collected Collecte of the same of the contract of

registrar by the fi

ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be execute. The bottom copy may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with certificate has been executed by the attending physician and completely filled cleath certificate assembly should be detached for use as a burial transit permit. INSTRUCTIONS ATTENDING PHYSICIAN

0

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH 6807

06775

Reg. Dist. No.

	1. PLACE OF DEATH	2. USUAL RESIDENCE (HOME) OF DECEASED
-1	COUNTY COUNTY CO MARYLAND	STATE Marylan Scounty Vanal
1	CITY (If outside corporate limits, write RURAL   LENGTH OF STAY	CITY (If outside corporate limits, Avrite RURAL and give neerest town)
	OR end give neerest town)	OR (III outside comporate limits, write KOKAL and give nearest town)
1	Willon Bridge Jay	TOWN A THE BOUNDARY
M	HOSPITAL OR	STREET Of rurel give (acetion)
1	INSTITUTION OR STREET ADDRESS	ADDRESS A VI
		1 anestan
- 1	3. NAME OF (First) (Middle)	(Lest) 4. DATE (Month) (Dey) (Yeer)
	(Type or Print)	DEATH ( 13 m/m)
1	5. SEX   6. COLOR OR   7. SINGLE, MARRIED,   8. DATE OF	
1	RACE WIDOWED, DIVORCED,	1870
	(Specify) March Cally	yrs. Months Deys Hours Min.
1	10e. USUAL OCCUPATION (Give kind of work   10b. KIND OF BUSINESS /	11. BIRTHPLACE (State of foreign country)   12. CITIZEN OF WHAT
- 1	done during meet of working life, even if OR INDUSTRY	COUNTRY?
	retired) Homellent	Lanol
	13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
	A W WY	61. 1-11 01.111
	John ando	Chendolla HIMAMA
	15. WAS DECEASED EVER IN U. S. ARMED FORCES?   16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
- 1	(Yes, ng, as unk.) (If Yes, give wer or detes of service)	-de 1 - 26 11 - 2 - 1
		Marie X will Willow Du dol 1
	I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	TIFICATION INTERVAL BEDWEEN
	I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	ONSET AND DEATH
_ 1	122, IMMEDIATE CAUSE (A) Chronic	all uppardition
-1		11 11
- 1	A 12 10 12 12 12 12 12 12 12 12 12 12 12 12 12	
- 1	DISEASES OR CONDITIONS, IF ANY, (B)	clero-org
	STATING UNDERLYING CAUSE LAST. DUE TO	
	(C)	
	II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING	
- 1	TO THE DEATH BUT NOT RELATED TO THE	
	DISEASE OR CONDITION CAUSING DEATH.	
	190. DATE OF OPERATION 196. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES NO
	21e. ACCIDENT WAS UNDERLYING 21b. PLACE (Home, ferm, fectory,	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)
- 1	OR CONTRIBUTING CAUSE OF DEATH OF INJURY street, office bidg., etc.)	
ŀ		21f. HOW DID INJURY OCCUR?
	While Not while	ZII. NOW DID INJUKT OCCUR?
	M, et work et work	
	22. I hereby certify that I attended the deceased from	- 1060 to 6-12 1060 illi
	22. I hereby territy main anchord me deceased from	, 17.5, that I last saw the deceased
4	alive on	
10M	SIGNATURE /) //	ADDRESS (Street, city, town, stete) PATE SIGNED
	1/V X CG 9 M.D.	Mening 13 2 de 1 6-12-61
5	23. BURIAL, CREMATION, DATE THEREOF   NAME OF CEMETERY OR	CREMATORY   LOGATION (City, town, of county) (State)
ñ	REMOVAL (SPECIFY)	M MA F
A15C 1-55	(Dunal Junits 60 Mondery 11.	Carlo Class VI to da to davil to Vad
S	24. REC'D BY REGISTRAR   REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
-1	HIN 1 5 too	(1) . 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1
	DATE JUN 15 '60	Remind & Which Muon midal
-	Cillay 2. Visies	VI J. W.

# CERTIFICATE OF DEATH

			3	
1 018 (Line ) on 18 (6 9 2) b				
		SEADSHIT		
TAN 100				and the same of
			1 1 NO	
	THE NAME OF STREET	Tel see you		
	MOTA STREET	Sep James R 194		A POLICE TO A STATE OF THE PARTY OF
	Jan Bridge M.			
			10 TO	
		1 (F) /S		
	The state of the s			CARSON VEHICLES
		104794 p 194130 NASSA (1983)		
	SUPPLIES FOR EACH OF THE PARTY			

CERTIFICATE OF DEATH

06276

e. IS RESIDENCE ON A FARM?

days

vears

(Stote)

YES NO X

1960

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

b. COUNTY

	0	P	/	h	
1	7	7	W	)	
	1		1		

PLACE OF DEATH

o. COUNTY

director, iled with

puo

physician attending physics remaye gned burial-transit cremotian, the

death certificate

physician R ATTEN 0 VR A15 (4)

Maryland Carroll Baltimore city b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) 6 mos. 12 days Baltimore Svkesville d. NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS 104 N. Greene Street Springfield State Hospital Middle 4. DATE DECEASED **OF DEATH** (Type or print) Sook June Leona Ann 8. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 19st birthdoy) Months February 23, 1912 Female White WIDOWED K DIVORCED T 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Stote or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) U.S.A. Maryland Clerk 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 17. INFORMANT 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO Springfield Hospital Records, Sykesville, Md. 530-16-4364 NO 1B. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Bronchopneumonia IMMEDIATE CAUSE (o) **DUE TO** Conditions, if phy, which Huntington's Chorea gove rise to immediate DUE TO couse (o), stoting the underlying couse lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY Chronic brain syndrome, unknown, unspecified cause, with psychotic react, yes No A 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, 20f. (City or lown) (County) foctory, street, office bldg., etc.) Hour o.m. Not while of work of work 21 I certify that (1) (this hospital) attended the deceased fram November 25,19 59 to June 7 saw the deceased alive on June 6. 1960, and that death accurred at 3:3%, from the causes and an the date stated above. 22a. SIGNATURI millo M.D. MED. DIRECTOR STAFF PHYS. 22c. PHYSICIAN'S 22d. ADDRESS NAME (Type) Springfield Hospital, Sykesville, Md. Abustin del Campo 23a. BURIAL CREMATION. 236. NAME OF CEMETERY OR CREMATORY REMOVAL (Specify) 25b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR'S SIGNATURE 25a. REC'D BY REGISTRAR Cirling & Three

MARYLAND

American Company of the St. St. the control of the co LAMBS TO THE RESIDENCE OF THE PARTY OF THE P The state of the s the second of th Commenced and the Commenced an 100 ALIENS - LEED TO SEE THE TOTAL TO A COUNTY OF THE PARTY OF THE PAR 

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH 6809

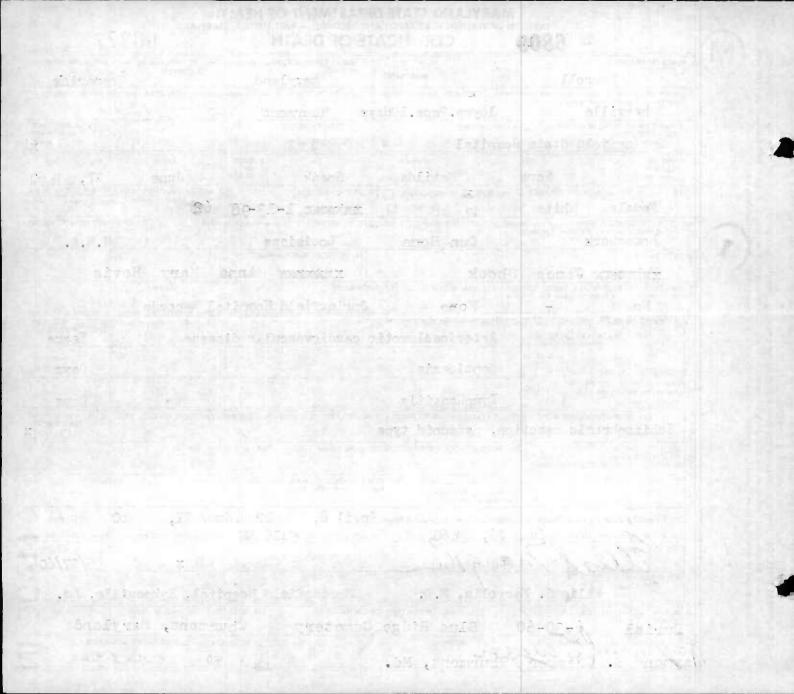
06777

1. PLACE OF o. COUNTY	Carroll		MARYLAND	2. USUAL RESIDENCE (V o. STATE Marvl		If institution:	_	fore admiss	
b. CITY OR RURAL o	TOWN (If outside corporate liming give neorest town)				f outside corporate lin	nits, write RURA	L ond give n	earest town	1)
Syl	cesville	18yrs.2mc	s.19day		nt	10	1	3	
OR INST	of HOSPITAL (If not in hospital, ringfield State			d. STREET ADDRESS  RFD #2					FARM?
3. NAME OF		-	A:		4 DATE	M W			
DECEASED (Type or pr			Aiddle lda	Speak	4. DATE OF DEATH	June			Yeor 19 60
S. SEX	6. COLOR OR RACE	7. MARRIED MEVER	AARRIED 8.	DATE OF BIRTH	9. AG	E (In years IF birthdoy) M		1	
Fe	emale White	WIDOWED A DIV	ORCED	Windows 1-			onths Days	Hours	Min.
10a. USUAL O	CCUPATION (Give kind of work	done 10b. KIND OF BUSIN	ESS OR INDUSTR		ite or foreign country)		12. CITIZEN	OF WHATC	OUNTRY
	ost of working life, even if retired OUSEWORK	Own H	ome	Louisia	na		U.	S.A.	
13. FATHER'S	NAME			14. MOTHER'S MAIDEN				0 911 9	
- H	known James	Shook		XUXXXXXXXXXXX	Anna	Mary	Hovi	S	
15. WAS DECE	EASED EVER IN U. S. ARMED FO		Y NO. 17. INFO	DRMANT		Address			14.5
	(If yes, give war or dates of	None	5	Springfield	Hospital	Records	3		
18. CAUS	SE OF DEATH [Enter only one o	ouse per line for (o), (b), or	d (c).]				IN	TERVAL BE	TWEEN
PA	PART I. DEATH WAS CAUSED 8Y: Arteriosclerotic cardiovascular disease							ONSET AND DEATH	
1	DUE TO								
Conditi	Conditions, if ony, which Septicemia						2413	Days	
	gove rise to immediate (DIETO								
	lying couse lost.  Lymphangitis							Days	
Z PA	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY								
15	Schizophrenic reaction, paranoid type								
I ∞ LOR CONT	20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) CR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								
	County   C								
21. I cer	tify that (1) (this haspita	al) attended the dece	ased fram Ar	oril 8.	1942 to June	27.	1960	that (I) (	we) last
	saw the decleased alive an June 26, 19.60, and that death accurred at 2.15M. Afform the causes and an the date stated abave.								
22o. SIG	LATURED 1 1	2	22b.DATE					b.DATE	
1	alless margh				M.D. ATTENDING MED. STAFF PHYS.   MED. STAFF PHYS.   6/27/60				
	22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS				
- Nom	Ellis S.	Margolin, M.I	).	Springfie	ld Hospita	1, Syke	sville	, Md.	L
	CREMATION, 23b. DATE THERE	OF 23c. NAME OF	CEMETERY OR	CREMATORY	23d. LOCATION (	City, town, or c	ounty)	(Stote	e)
Buri	(Specify) 6-30-6	0 Blue	Ridge C	emetery	Thurn	ont, I	Maryl	and	
	DIRECTOR'S SILVETURE	ADDRESS		25a. RE	C'D 8Y REGISTRAR	2Sb. REGISTR	AR'S SIGNAT	URE	
Haymon	d E. Creager	Thurmont	Md.	DATE	1111 1 '60	0.	T. bun 8. +	Trave	
L		4			THE REPORT OF THE PERSON NAMED IN				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 he after death. Page 4 may be refuned by the haspital an attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached far use as the burial-transit permit. Then please remave carban papers. Pages 1 and 2 should be filled with the State Board at Health priar to burial, cremation, ar remayal, and in any event, within Zertages after death.

VR A1S (4) 15M 9/S9



after deoth. Page 4

completely filled in by the funeral director

TO HOSPITALING RATENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hamay be refused by the hospital or attending physician.

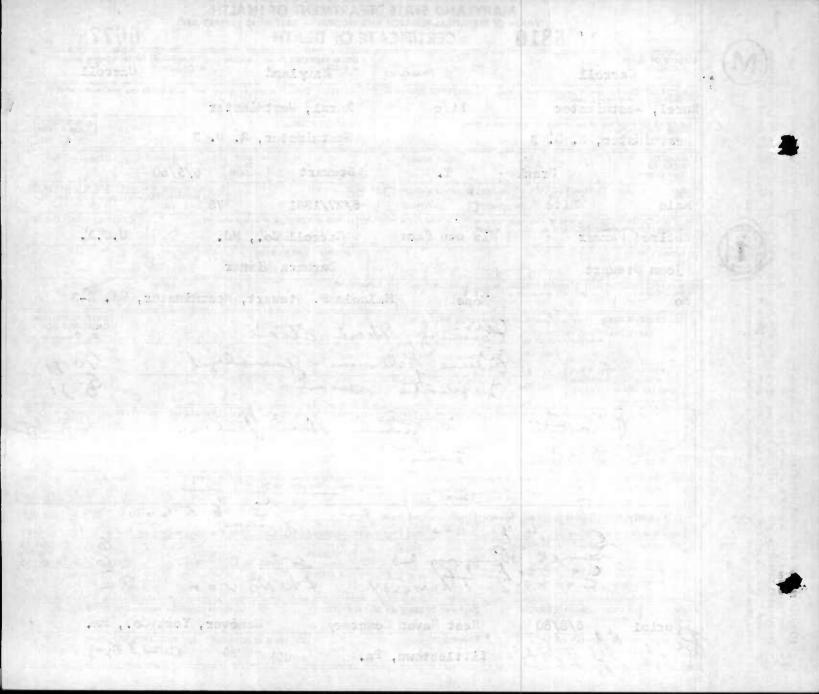
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in page 3 shauld be detached far use as the burial-transit permit. Then please remave recording pers. Pages 1 are the State Board of Health priar to burial, crematian, ar removal, and in any event, which is priver death.

VR A1S (4) 1SM 9/S9

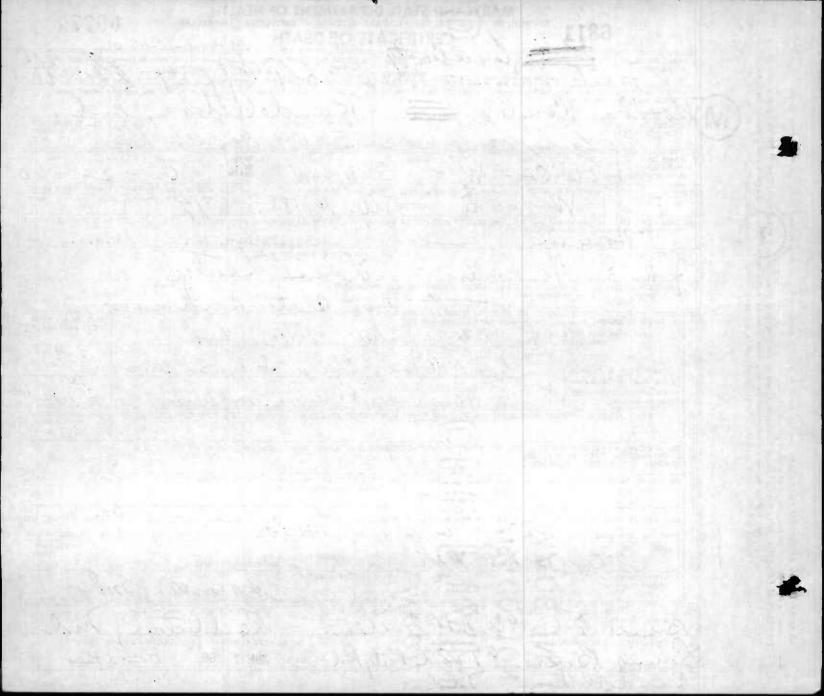
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
6810 CERTIFICATE OF DEATH

06778

				77					
1. PLACE OF DEATH a. COUNTY Cari	ro11		MARYLAND	2. USUAL RESIDENCE (W	here deceased li	ived. If instituti b. COUNTY			sion)
b. CITY OR TOWN (IF RURAL and give ner Rural, Westi	arest tawn)	c. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest tawn)  Rural. Westminster							
d. NAME OF HOSPITA OR INSTITUTION Westminster	AL (If not in hospital, g	jive street	address)	/ d. street ADDRESS / Westminste	er, R. D	. 3			FARM?
3. NAME OF DECEASED (Type or print)	Fian Pran		Middle <b>T</b> •	Stewart	4. DATE OF DEATH	6/5/6		/	Year
S. SEX Male	6. COLOR OR RACE White	7. MARE	RIED NEVER MARRIED DIVORCED DIVORCED	8. DATE OF BIRTH 8/27/1881		AGE (In years last birthday)  8 yrs.		YEAR IF UNDI	Min.
10a. USUAL OCCUPATIO during mast af warki Retired Par	N (Give kind of working life, even if retired	dane 10b.	KIND OF BUSINESS OR INDI	USTRY 11. BIRTHPLACE (State				S.A.	COUNTRY
John Stewa	art			14. MOTHER'S MAIDEN  Barbara			45.5		
1S. WAS DECEASED EVER	IN U. S. ARMED FOR If yes, give war or dates of s	ervice)		alcolm F. Ster	wart, We	Add stminst		. R-3	
	TH WAS CAUSED 8Y: IMMEDIATE CAUSE (compared to the compared to	, 0	ne for (a), (b), and (c).]  orange A  teno A ele  uplatti	Heart all	and	zul		INTERVAL 8EONSET AND	DEATH
PART II. OTH	rostata	DITIONS	CONTRIBUTING TO DEATH BU	in Hun	e faul	mer	VEN IN PART 1	PERFC	AUTOPSY RMED?
(IF EITHER, NOTIFY	S UNDERLYING  CAUSE OF DEATH MEDICAL EXAMINER)	20b. DES	CRISE HOW INJURY OCCURR	ED. (Enter nature af injury in	n Par <b>U</b> i ar Part II	l af item 18.)			
Y 20c. TIME OF INJURY Haur a. m. p. m.	10								
	ATTENDING MED. STAFF DIRECTOR PHYS.   22c. PHYSICIAN'S  22d. ADDRESS  22d. ADDRESS								
23a. BURIAL, CREMATION REMOVAL (Specify) Burial	6/8/60	)F	23c. NAME OF CEMETERY Rest Haven C		200	ON (City, town,	- "	Pa. (Slai	te)
24 EUNERAL DIRECTOR'S	A LITT	Po	ADDRESS Littlestown,		O'D BY REGISTRA		STRAR'S SIGN		



1 1/2		MARYLAND STATE DEPARTMENT OF HEALTH  DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  () () 779
		CERTIFICATE OF DEATH Film 2264 6-10-60 et
Page 4 director, led with	1. P	LACE OF DEATH  COUNTY  A. COUNTY  MARYLAND  2. USUAL RESIDENCE DAMES declosed lived. If institution: Residence before admission of the country of the countr
earth.	7	CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 1b c. CHY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
offer de 2 should		I. NAME OF HOSPITAL (If no) in haspital, give street address)  OR INSTHIBUTION  OR INSTHIBUTION  OR INSTHIBUTION  THE STREET ADDRESS  ON A FARM?  YES \( \sum \text{NO} \sum \text{O} \)  YES \( \sum \text{NO} \sum \text{O} \)
Pho Odi		IAME OF First Middle Last 4. DATE Manth Day Year
ithin 2 ly filli Pages death	5. 5	LIFT LINE OF A VICADILIF LINE OF A LINE
of the second	10-	USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Stote or foreign country)  12. CITIZEN OF WHAT COUNTRY?
haurs haurs	100	during mod of working life, even if refired)  Randallstown, Md.  U.S.A.
ion corpo	13.	EATHER'S NAME
g physici remave vent, with	1S.	Address  Address  Address  Address  Address
death ce tending please re any eve	1	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
atter atter in ar		PART I. DEATH WAS CAUSED BY: ONSET AND DEATH IMMEDIATE CAUSE (a) Carbone Jachure, Carbonoschrotic
that the by the it. The al, and		Conditions, if any, which) (b) bush besieve, Chrome brain Syndrome. 1959
equires signed it perm r remav		gave rise to immediate cause (a), stating the under- lying cause last.  DUE TO  (c) Car Cunoma livery (remond mefactors)  2 me
e law r physicio os been al-trans ation, a	CATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED?  YES NO
AN: The ending ficate he buri	CERTIFIC	20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 1B.)
HYSICI I ar oth is certif use as ta burio	MEDICAL	20c. TIME OF INJURY Month, Doy, Year Haur o. m.  P. m.  19  20d. INJURY OCCURRED While at work of wark
oing prior		21. I certify that (I) (this hospital) attended the deceased from 1939, 19, to 2 me, 19 that (I) (we) los
ATTENC by the 1 CTOR: / detach F Health		saw the deceosed olive on 1960, and that death occurred at 7MM, from the causes and on the date stated above  22a. SIGNATURE  ATTENDING  MED.  STAFF  PHYS.  DIRECTOR  PHYS.
AL DIRECTOR DI		22c. PHYSICIAN'S NAME (Type)  22d. ADDRESS  Aprently, ml
NER NER tate	230	BURIAL, CREMATION. 23b DATE THEREOF 22 NAME OF CEMETERY OR GREMATORY 23d LOCATION (City, town, or county) (Stote)
TO HO TO FU Poge the S	24.	FÜNERAL DIRECTOR'S SIGNATURE  ADDRESS  ADDRESS  250. REC'D BY REGISTRAR 250. REGISTRAR'S SIGNATURE
VR A15 (4) 1SM 9/S9	2	Joung Byers 8728 Librity Rd. DATE JUN 7 '60 Citing S. House
N. C.	1	Candallettour, md.



by the funeral director,

after death. Page 4

TO HOSPILL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hard after demay be remined by the hospital or attending physicion.

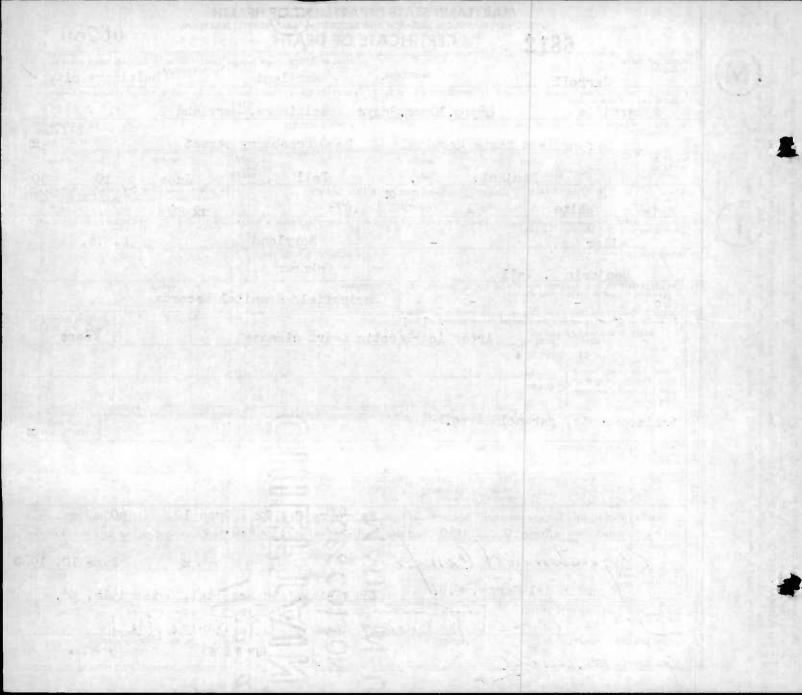
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the functions a should be detached for use as the burial-transit permit. Then please remave carbon papers, Pages 1 and 2 should the State Board at Health prior to burial, cremation, or remaval, and in any event, within 72 hours after death. VR A15 (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

**CERTIFICATE OF DEATH** 6812

-1	1	R	7	8	13	
1	,	U	0	0	13	

1. PLACE OF DEATH					2. USUAL RESIDENCE	E (Where deced			n: Residence b	efore admi	ssion)
6. COUNT	Carroll		MAR	YLAND	o. STATE Mar	yland	b. (	COUNTY I	Baltimo	re ci	ity /
	(If autside corporate limi	its, write	c. LENGTH OF STA	Y IN 1b	c. CITY OR TOW	N (If outside co	rporote limits	, write RU	RAL and give	nearest tov	vn)
RURAL and give		1	8yrs.10mo	s. 3da	vs Balt	imore,	Maryla	nd		3 VO ,	1,4
d. NAME OF HOSP OR INSTITUTION	PITAL (If nat in haspital, g				d. STREET ADDRI					e. IS RE	SIDENCE A FARM?
OK INSTITUTION	Springfield	d Stat	e Hospita	1	2660 Pr	esberry	Stree	t			NO T
3. NAME OF DECEASED	Fie	rst	Middl	e	Last	4. DAT		Month	1	Day	Yeor
(Type or print)	Ве	enjami	in A.		Tall	DEA	TH	June	]	.0	19 60
S. SEX	6. COLOR OR RACE	7. MARRII	ED NEVER MARR	IED 🔯	B. DATE OF BIRTH		9. AGE		Months Do	-	1
Male	White	WIDOWED	DIVORC	ED 🗌	1873		52	86	Months Doy	rs Hours	Min.
10a. USUAL OCCUPAT	TON (Give kind af work arking life, even if retired	done 10b. K	IND OF BUSINESS	OR INDUS	TRY 11. BIRTHPLACE	(State or foreign	n country)		12. CITIZEN	OF WHAT	COUNTRY
_	ilor	"	-		Mar	yland			U.S	. A.	
13. FATHER'S NAME					14. MOTHER'S MAI	DEN NAME	1110				
Re	enjamin F. T	רופי			Unkno	own					
IS. WAS DECEASED EV	ER IN U. S. ARMED FOR	CES? 16. S	OCIAL SECURITY NO		FORMANT			Addre			
(Yes, no, or unknown)	(If yes, give war or dates of s	service)	-	S	pringfield	d Hospit	tal Re	cords			
IR CAUSE OF DE	EATH [Enter only one co	use per line	for (a) (b) and (c	11					11	NTERVAL E	ETWEEN
	EATH WAS CAUSED BY:	Α.			ic heart d	i conco				Year	D DEATH
140	IMMEDIATE CAUSE (c	-	reer Tose	Teror	To neare c	1726926				rear	3
, 05 (	DUE TO	)									
Conditions, if		)(									
cause (o), stating									-		
lying couse lost											
Schizon	THER SIGNIFICANT CON	DITIONSCO	ONTRIBUTING TO D	EATH BUT	NOT RELATED TO THE	TERMINAL DISE	ASE CONDI	TION GIVE	N IN PART 1(c	19. WAS	AUTOPSY
3	, ,		O.P.							YES [	
Schizopi  Schizopi  20a. ACCIDENT W OR CONTRIBUTION (IF EITHER, NOTIF	VAS UNDERLYING []	20b. DESC	RIBE HOW INJURY	OCCURRED	. (Enter noture of inju	ory in Part I or	Port II af ite	m 1B.)			
	Y MEDICAL EXAMINER)										
20c. TIME OF INJU		ar 20d. IN.	JURY OCCURRED		CE OF INJURY (Home		City or town)		(Coun	ity)	(Stote
Haur o. m	10	While of work	Nat while	rac	tary, street, affice bld	g., etc.)					
	nat (I) (this haspito			1.5	Pahmuanur Ø	10.12	Tune	10	10 60	11	
saw the dece	ased olive on Jun	e_9	190U , one	d that d	eath occurred at	JITM, 419	off the car	uses and	on the do		
22d. SIGNATURE	2007-	lal	16		ATTENDING	MED.	_ STAFF		_		2b. DATE SIGNED
22c/PHYSICIAN'S	gianni	cess	Christ	10 1	A.D. PHYS.   22d. ADDRESS	DIRECTOR	PHYS.	301	11	me l	0, 190
CNAME (Type)	1 3-7	0	· M D		220. ADDRESS						
/	Agustin del	Campo	o, M.D./		Springf	ield_Ho	spita	L. Sy	kesvil	Le, Mo	1
23a BURIAL CREMATI		OF /	230 NAME OF CEN	METERY OF	CREMATORY	234, 10	CATION (Cit	y, town, ar	county)	(Ste	ote)
	4 13	-60	VAIN. Gr	alin	y Down	170	lim	OSE,	Wd		
24. FUNERAL DIRECTO	R'S SIGNATURE		ADDRESS		250	REC'D BY REC		Sb. REGIST	TRAR'S SIGNA		
Trank	H Muss	11	No. No. of Sci.		DA	אטעי,	1 5 '60		- 3.	Maria	
7	7										

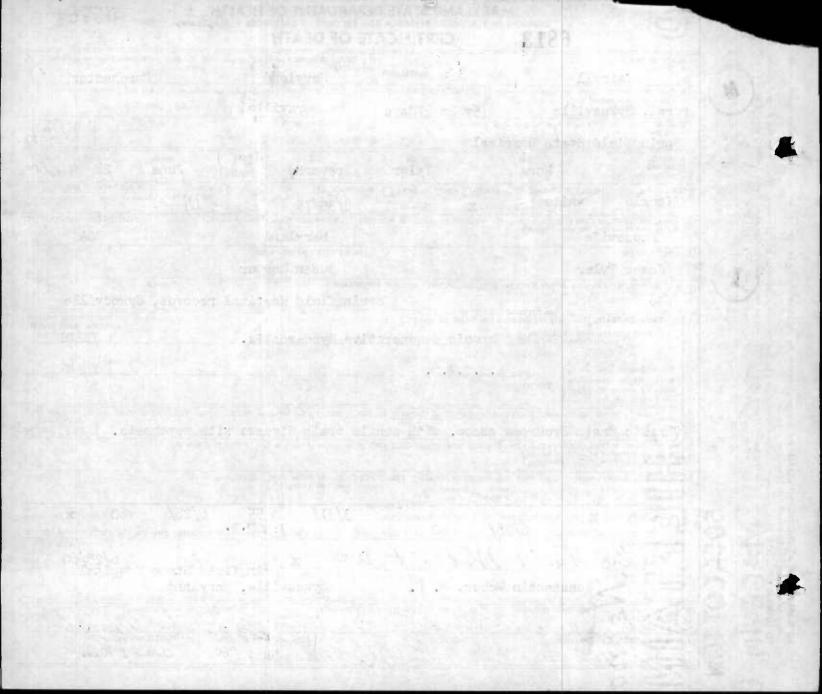


MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND 6813 CERTIFICATE OF DEATH

06781

1.	PLACE OF DEATH						JSUAL RESIDENCE (	Where deceas			on: Reside	nce befo	ore admiss	sion)
	o. COUNTY Car	roll		N	ARYLAND	1	Maryla Maryla	nd	Ь. С	OUNTY	Doro	ches	ter	/
		f outside corporate limi	its, write	c. LENGTH OF S	TAY IN 16		c. CITY OR TOWN (	If outside corp	porote limits,	write R	URAL ond	give ne	arest town	(۱)
:	RURAL ond give no rural. Syk			5y 2m 2'	7davs		Hoopersv	ille		C	9 X	4000	7	
		AL (If not in hospital, g	ive street				d. STREET ADDRESS						e. IS RES	IDENCE FARM?
		ld State Ho	spit	al										NO K
3.	NAME OF DECEASED (Type or print)	Nore			yler		Traverse	4. DATE OF DEAT	н	Jun		28		Yeor 19 60
5.	female	6. COLOR OR RACE white	7. MARE	RIED NEVER M.	ARRIED	B. DA	8/30/75		9. AGE (I lost bi	n yeors thdoy)	IF UNDE Months	R 1 YEAR Doys	Hours	Min.
10	. USUAL OCCUPATION	ON (Give kind of work	done 10b.	KIND OF BUSINE	SS OR INDU	STRY	11. BIRTHPLACE (Sto	ote or foreign	1		12. CI	TIZEN O	FWHAT	OUNTRY?
	Housew	king life, even if retired	)			30	Maryla	nd				U.	SA	
13.	FATHER'S NAME			HALING .	4000	14	. MOTHER'S MAIDER	N NAME						
	James T	yler					Susan H	looper						
15	WAS DECEASED EVE	R IN U. S. ARMED FOR		SOCIAL SECURITY	NO. 17. II	NFOR				Add	ress			
(1)	No No	(If yes, give war or dates of s	ervice)		S	pri	ngfield H	lospita	l rec	ords	, Syl	cesv	ille	
		ATH [Enter only one co ATH WAS CAUSED BY: IMMEDIATE CAUSE (c	Ch			tiv	e Myocard	lotis.				ON	ERVAL BE SET AND EARS	
	Conditions, if o gove rise to i couse (o), stoting lying couse lost.	mmediote (	)	S.C.V.D.								Y	EARS	
Z	PART II. OTH	HER SIGNIFICANT CON		CONTRIBUTING TO	DEATH BUT	TNOT	RELATED TO THE TEL	RMINAL DISEA	ASE CONDIT	ION GIV	VEN IN PA	RT 1(o)	19. WAS	AUTOPSY RMED?
CATION	Chronic B	rain Syndro	ome a	ssoc. wi	th sen	ile	brain di	sease	with	psyc	hosis	3.		NO 🔀
CERTIFI	200. ACCIDENT WA OR CONTRIBUTING (IF EITHER, NOTIFY	AS UNDERLYING  CAUSE OF DEATH MEDICAL EXAMINER)	20b. DES	CRIBE HOW INJU	RY OCCURRE	ED. (En	ter noture of injury	in Port I or P	ort II of iten	n 1B.)				
MEDICAL	20c. TIME OF INJUR Hour o. m. p. m.	Y Month, Doy, Ye	ar 20d. II While of wor	NJURY OCCURRED Not while			OF INJURY (Home, fo street, office bldg.,		ity or town)		10	(County)		(Stote)
	saw the deceas	at <b>XX)</b> (this haspita	1) attend 5/28/				3/31/ accurred at 3	19_55 to					e stated	
	220. SIGNATURE	notanti	1.7	Veber	/ H.	Do.	ATTENDING PHYS.	MED. DIRECTOR [	STAFF PHYS.		e Hos	6/2	8/60	b. DATE SIGNED
	22c. PHYSICIAN'S NAME (Type)	Konstant	in We	ber, M. I	D.			ille,				PAT 0	C)L.	
23	PEMOVAL (Specify)	Subje	OF 1960	23c. NAME OF	CEMETERY C	me	ematory morial Tan	X as	ATION (CIN	dde	0 1	Non	01/10	and and
24	FUNERAL DIRECTOR	& SIGNATURE	nel	ADDRESS	Franky	ida	- Mark	EC'D BY REGI	'60		STRAR'S S	. 4		

TO HOSPITY VR A15 (4) 1SM 9/59



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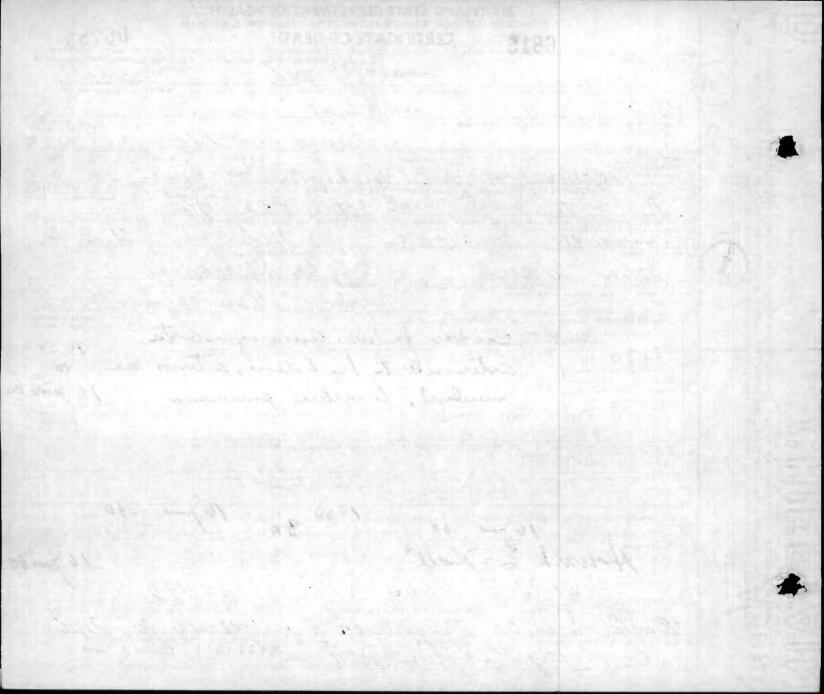
0017				
1. PLACE OF DEATH o. COUNTY acres of	MARYLAND	2. USUAL RESIDENCE (Where deceased line) o. STATE	b. COUNTY	te before admission)
b. CITY OR TOWN (If autside carporote limits, we RURAL and give nearest town)	c. LENGTH OF STAY IN 16	c. CITY OR TOWN (If outside corporate	e limits, write RURAL ond g	ive nearest town)
d. NAME OF HOSPITAL (If not in haspital, give s OR INSTITUTION	Home	d. STREET ADDRESS	Road	e. IS RESIDENCE ON A FARM? YES NO
3. NAME OF DECEASED (Type or print) MARY A	NNA TRO	Lost 4. DATE OF DEATH	June	Day Year
16 . 1. 1	MARRIED NEVER MARRIED DOWED DIVORCED	B. DATE OF BIRTH 9.	lost birthday) Months	1 YEAR IF UNDER 24 HR Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDU	STRY 11. BIRTHPLACE (Stote or foreign coun	12. CITIZ	SA
13. FATHER'S NAME	(ec)	Mary E. Stores	venor	
15. WAS DECLASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown) (If yes, give war or dates of service)		Marin Schot	- Address	Me Jud
1B. CAUSE OF DEATH [Enter only one cause   PART I. DEATH WAS CAUSED BY:   IMMEDIATE CAUSE (o)		, bilateral, acute,	causative	INTERVAL BETWEEN ONSET AND DEATH
Conditions, if ony, which ) (b)	organism undeter			4 days
gove rise to immediate couse (a), stating the <u>under-lying</u> couse lost.		and chronic myocard		20 yrs.
hypertrophic ar	thritis, chronic:	r not related to the terminal disease of cholescystitis, chr	onic	19. WAS AUTOPS' PERFORMED? YES NO
OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	. DESCRIBE HOW INJURY OCCURRE	D. (Enter nature of injury in Port I or Part II	at item 18.)	
Hour a.m.		ACE OF INJURY (Hame, farm, 20f. (City or cotory, street, office bldg., etc.)	r town) (C	County) (Stat
21. 1 certify that (I) (this haspital) at saw the deceased alive an 6/1/			5/2/60 19 ne causes and an the	
22a. SIGNATURE	,	M.D. ATTENDING MED. DIRECTOR	STAFF PHYS.	22b. DATE SIGNE 6.2.60
Vm. H. Lawson	n, Jr., M.D.	Sykesville, Ma	ryland	
23g. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) 6-5-60	23c. NAME OF CEMETERY OF	Claud Oakla	DN (City, town, or county)	Ula MA
24. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS ADDRESS	DATEJUN 7 '60	25b. REGISTRAR'S SIC	

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove catbon papers. Pages 1 and 2 should be filed with the State Board of Health priar to burial, cremotion, or removal, and in any event, within 72 hours after death. after death. Page 4 R ATTENDING PHYSICIAN: The law requires that the deoth certificate by executed within 24 TO HOSPITA VR A1S (4) 15M 9/59

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TO HOSPITA RATTENDING PHYSICIAN: The law requires that the death certificate be executed within	may be received by the haspital ar attending physician.  TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely fi	page 3 shauld be detached far use as the burial-transit permit. Then please remave carban papers. Page	the State Baard of Health prior to burial, cremation, or remaval, and in any event, within 22 hours after dea
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	6815 CERTIFICATE OF DEATH	06783
M	1. PLACE OF DEATH a. COUNTY  MARYLAND  2. USUAL RESIDENCE (Where deceased lived. If institution of STATE b. COUNTY)	in: Residence before admission)
141	b. CITY OR TOWN (If autside carporale limits, write RRARA and give neasest town)  1. C. CITY OR TOWN (If autside carporate limits, write RRARA and give neasest town)  1. C. CITY OR TOWN (If autside carporate limits, write RRARA and give neasest town)  1. C. CITY OR TOWN (If autside carporate limits, write RRARA and give neasest town)	JRAL and give nearest tawn)
7	d. NAME OF HOSPITAL (If not in hospital, give street address)  OR INSTITUTION  d. STREET ADDRESS  MINIMAL HELL ROAM	e. IS RESIDENCE ON A FARM? YES NO
	3. NAME OF DECEASED (Type or print) PAROLINE (CARRIE) E. Wikk, AMS 4. DATE OF DEATH CLASS	e 16 1960
	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH (6st birthdoy) VIDOWED DIVORCED DIVORCED 7. 1883 9. ASE (In years	Months Days Haurs Min.
-	10a. USUAL OCCUPATION (Give kind of wark done during most of warking life, even if retired)  HAUSLUGGE (Stote or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	13. FATHER'S NAME Ware 14. MOTHER'S MAIDEN NAME LICEARED OF	N
	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, notify runknown) (If yes, give war or dates of service)	seville med.
	1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  Carbar Farlure, Caneurs onto	INTERVAL BETWEEN ONSET AND DEATH
	Canditions, if any, which ) (arternales to beat deare, arterior	eleras to
	gave rise to immediate cause (a), stating the under- lying cause last.  DUE TO  (c) freulyed, Irrachial frecuories	16 Jame
0	PART 11. OTHER SIGNIFICANT CONDITIONS CONTRIBUT NG TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVES	EN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES NO
	20a. ACCIDENT WAS UNDERLYING DOR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
	20c. TIME OF INJURY Manth, Day, Year Haur o. m.  p. m.  19  20d. INJURY OCCURRED While Not while of work of otwork of work of	(Caunly) (State
	21 I certify that (I) (this haspital) extended the deceased fram 1950 19ta 16 hunces and the deceased alive an 16 hunces and that death accurred 3 A.M. from the causes and	d on the date stated above
1	220. SIGNATURE ATTENDING MED. STAFF PHYS. DIRECTOR PHYS. D	22b. DATE SIGNE
	22c. PHYSICIAN'S NAME (Type) HOWARD E. HALL SI/CESVILLE, M.	0,
	23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, lown, REMOVAL (Specify) (6-18-60) Mt Unless	or county) (Stote)
Eg.		STRAR'S SIGNATURE
1 00		



CERTIFICATE OF DEATH il director, filed with 1 PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. COUNTY b. COUNTY MARYLAND funeral b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If oyiside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) d. NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE OR INSTITUTION ON A FARM? YES NO NAME OF First Middle DATE Lost Manth Day Yeor DECEASED (Type or print) DEATH 19 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. lost birthday) Months Hours Min. WIDOWED [ DIVORCED P yrs. 100. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Stote or foreign country) 12, CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME off physician move IS. WAS DECEASED EVER IN U. S. ARMED FORCES? 1: SOCIAL SECURITY NO. 17. INFORMANT Address 214-01-176 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c). INTERVAL BETWEEN OMSET AND DEATH 0 PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to immediate DUE TO couse (o), stoting the underlying couse lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES T NO 7 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port 1 or Part II of item 18.) 20c. TIME OF INJURY Month, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) Doy. (County) (Stote) foctory, street, office bldg., etc.) o. m. While Not while of work of work D. m 21. I certify that I attended the deceased from 1960, that I last saw the deceased , and that death accurred at TIN M, from the causes and an the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATUR PHYSICIAN'S NAME (Type) 3 220. BURIAL, CREMATION. 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, Iown, or county) - (Stote) REMOVAL (Specify) 0 23 FUNERAL DIRECTOR'S SIGNATURE ADDRESS 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE 15M 9/SS DATE ALLAL Civil 7 S. Thouse

death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

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